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CHILDREN OF SUBSTANCE ABUSERS

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILIES, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

EXAMINING THE RISKS FOR CHILDREN WHO ARE BORN TO, OR ARE GROWING UP WITH PARENTS WHO ABUSE DRUGS

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CHILDREN OF SUBSTANCE ABUSERS

MONDAY, FEBRUARY 5, 1990

U.S. Senate
Subcommittee on Children,
Families, Drugs and Alcoholism
of the Committee on Labor and Human Resources
New York, NY.

The subcommittee met, pursuant to notice, at 2:10 p.m, 26 Federal Plaza, New York City, NY, Senator Christopher J. Dodd (chairman of the subcommittee) presiding.

Present: Senator Dodd.

Opening Statement of Senator Dodd

Senator Dodd. The Subcommittee on Children, Families, Drugs and Alcoholism will come to order. Let me first of all welcome all of you here this afternoon to this subcommittee hearing to discuss the subject of Children of Substance Abusers. This is one of a series of subcommittee hearings on the effects of substance abuse on children and their families. Earlier hearings looked at preventing drug abuse among children and youth, a phenomenon that occurs at alarmingly young ages. Today, however, we are going to focus on the risks for children who are born to, or are growing up with parents who abuse drugs.

Children are the hidden victims in today's drug epidemic, mainly because many women are attracted to crack cocaine. This morning, I saw some of the youngest victims of drug abuse—tiny, tiny infants exposed to drugs even before birth, struggling for life in an intensive care nursery at the Metropolitan Hospital. It was a devastating and, at the same time, moving sight. By one estimate, as many as 375,000 drug exposed infants are born nationally each year. Many of these infants face medical complications and possible developmental delays, the dimensions of which are frankly unknown. Some are abandoned. Some languish in hospitals. Many go into foster care. Relatives frequently assume responsibility, with or without support from child welfare agencies.

But drug exposed infants are only part of the story. Many more children are at risk for abuse and neglect because their parents or some other member of the household abuses drugs. The National Committee for Prevention of Child Abuse estimates that 675,000 children each year are seriously mistreated by an alcoholic or drug abusive caretaker. We often don't see these children until they arrive at school dirty and hungry, are found during crack house raids, or come into the emergency room beaten and bruised. Most tragic of all, drug abuse figures in child deaths with increasing frequency.

For many families, drug abuse is simply a symptom, one more legacy of poverty, like inadequate housing, poor nutrition, lack of skills or education. If their problems become visible enough, the children may enter a welfare system strained by rapidly rising caseloads. In my own home State of Connecticut, about two-thirds of serious abuse and neglect referrals have drug involvement. Here in New York City, as in other places hard hit by drugs, foster care placements have risen dramatically in the past few years. The children in these cases often are quite young, infants and toddlers, the most vulnerable to abuse and the most invisible to society. But there are not enough foster parents for them, especially foster parents who can deal with the special needs of addicted babies.

Today we are going to look at the disturbing implications which drug abuse holds for our children and their families. We also will examine the very real tensions that working with substance abusing families creates for the child welfare and drug treatment systems. On the one hand, we want to help parents overcome their drug problems and preserve and strengthen their families. But, we also have a responsibility to protect vulnerable children and provide them with a stable and nurturing environment.

I will be looking toward solutions that see the family as a seamless garment, solutions that address the family's problems comprehensively and seek to get to the underlying problems of poverty. No one suffers more from our fragmented human services than substance abusing families. For them, piecing together the services they need to carry on their daily lives is often impossible. At a policy level, we often talk of multiproblem families, but our programs address individual needs, such as housing or parenting skills or drug treatment. Rarely do we seriously talk about looking at the family as a whole and organizing our services accordingly. Finally, we must look for ways to reach out to at risk families earlier, before they reach the crisis point.

This afternoon, I am pleased to welcome the Hon. David Dinkins, who as the new Mayor of New York City, will be dealing with these complex issues first hand. Then, we will hear from some of the people directly affected by this wave of drug abuse. Most notably, we have several young people here this afternoon with us who have been courageous enough to come forward and tell us about their lives as children of substance abusers. We will also hear from social workers and foster parents, who face on a daily basis the task of putting these children's lives back together. Finally, we have with us several experts in child welfare and drug treatment who will describe for us the impact of drugs on child welfare and the potential for treating the entire family.

At this point, it gives me a great deal of pleasure to present to the gathering here before the subcommittee an old friend and also the new Mayor. Mayor Dinkins and I have known each other for a number of years. He has been involved in public service for a quarter of a century in this State and in the City. We got to know each other when he was borough president, going back 4 or 5 years ago, and I had the pleasure of working with him on a number of occasions then. I look forward, as I told the Mayor privately, coming from a neighboring State with so many regional problems, to working closely with him, Mayor, I can tell you this, this afternoon, that the Connecticut Congressional delegation stands ready and willing to work with you and the delegation from New York City on any matter that comes up about which you are concerned. As Mayor, of course, you have a number of serious problems to deal with and this is not the least of them. Anonymous testing found in this City alone, that 11 to 20 percent of newborn infants are testing positive for illicit drugs. Almost one out of every five children in this City is testing positive.

Mayor, we know of your commitment for helping these children and all the children of New York City from the fact that you dedicated your inaugural address to children. I found that a very compelling thing to have done. The Governor of this State has declared that this decade be declared the decade of the child, so New York State and City have two leaders who are deeply committed to these issues. We are pleased and honored to hold this hearing today in your City, although I want to make the point that it is not just a New York problem, but a national problem. But, as you pointed out, this is a good laboratory to look at the problems that are growing larger and more serious given the population of this City.

So, we thank you for taking the time to be with us. It is a pleasure to have you come before this committee. I wanted to say this was the first Congressional committee that you have testified in front of as the sworn in Mayor, and I am going to say that anyway and let you contradict me if you would like.

Mayor DINKINS. I wouldn't dare.

Senator DODD. Thank you.

STATEMENT OF HON. DAVID DINKINS, MAYOR, NEW YORK CITY

Mayor DINKINS. Senator, thank you so much. I am delighted to see you again and to have an opportunity to discuss this subject. I am joined here by Carmen Rivera who is a Director of Health Policy on my right, and Donna Lawrence, Director of Office of Children and Families on my left. These young women have been with me in the Borough President's Office and just the other day I formally announced their appointments to these respective positions. They are two very knowledgeable and caring people and I am delighted that the City has the benefit of their expertise in these areas.

It is true that I believe that New York City is a laboratory for many of the urban ills. This very day, we had a delegation of your colleagues from the House lead by Senator Gephard here looking at infrastructure problems and some member of the press wanted to know are we here because New York is crumbling or what, and the real answer is New York is an excellent laboratory, looking at problems of homelessness, AIDS, drugs and etc., and so I am pleased that you have come here because this is a communications capital of the world, and the word sort of tends to get out and what we need, of course, is your colleagues and, in the Congress, being made the more aware as you are of these problems with which we are beset and, of course, our President to understand that we have got to find some ways to do something with what we call a piece dividend. We have got to take some of these moneys that we are putting into stock piling of weapons that we perhaps will never use—a Stealth bomber costs one-half billion dollars and it would go a long way toward solving some of the problems of our urban centers. So, Mr. Chairman, I thank you for permitting me to testify here today and for holding this hearing here in New York City where we know all too much about the impact of substance abuse on children.

Mr. Chairman, my testimony today will be harsh and painful because for the children of this City, life is too often harsh and painful.

It is customary for the Mayor of a city to cast the best light possible on conditions in his or her city. But, I won't be doing that today. Instead, I want to point the spotlight into the darker corners of this City's neighborhoods, the places where kids play in school yards covered with hypodermic needles and crack vials; the places where babies are born underweight and addicted to crack; the places where kids shudder every time a door slams or a book falls because they fear it is another round of druglords' gunfire; the places where many of our children face the sunset of opportunity in the very dawn of their existence.

I am glad you have brought your subcommittee here today, Mr. Chairman, because I have a simple and clear statement for you to take back to Washington with you: the children of New York need your help.

Two national ills have now combined into as great a challenge as this City has ever faced. Crack and AIDS have merged into a public health disaster that threatens the very ability of this City to enter the next century with our social fabric in tact and our local work force capable of competing in the national and international economy.

Consider these facts:

—Anonymous testing of newborns in New York City hospitals revealed that 11 to 20 percent tested positive for illicit drugs.

—With maternal drug use a contributing factor to low birth weight in newborns, New York City has seen a 10 percent increase in the past 10 years in the proportion of low birth weight infants.

—Normal weight babies born to drug using mothers have more than tripled the risk of dying within their first year as normal weight infants whose mothers do not abuse drugs.

—Seventy-six percent of the pediatric AIDS cases in New York City were caused by either direct or indirect maternal IV drug use.

—According to the New York City Health and Hospitals Corporation, about 60 percent of the infants awaiting foster care placement for 10 days or more had substance abuse mothers.

—In fiscal year 1989, there were 4,875 babies reported to the City's Child Welfare Administration (CWA) because of a positive toxicology for drugs—14 percent more than a year ago and 268 percent more than in 1986, when CWA first began tracking this information. I guess it was called Special Services for Children at that time. We have since changed the name.

—Of the 45 child abuse related fatalities reviewed by the City's Child Welfare Administration in 1989, 71 percent involved substance abuse; that is up from 24 percent in 1988.

Therefore, Mr. Chairman, it is no exaggeration to say that the impact of substance abuse on children is disease, despair and death.

The consequences of the drug epidemic and the crime it causes are worse when we examine those who have lived the fewest years because they have the most years left to live.

Today's physical and psychological wounds will become tomorrow's social and economic scars.

The first follow-up studies of babies born to mothers using crack show that in early childhood, they have serious difficulty relating to their world, making friends, playing like normal children and feeling love for their mothers or primary caretakers. This means a lot to me. You mentioned our Governor who declared this to be the decade of the child, well, the Governor and I are grandfathers and we understand about children.

Prenatal exposure to illegal drugs, particularly crack, seems to be "interfering with the central core of what it is to be human," according to a research psychologist at the National Institute of Drug Abuse in Bethesda, MD.

And the studies suggest that without help, the children of addicted mothers may be unable to develop into adults with basic employment skills and unable to form close human relationships.

The *New York Times* recently reported that psychologists tell of children who have learned to avoid eye contact with passers-by, children who can tell the kind of gun being fired down the block by its sound. Teachers tell of star pupils who wither socially and academically after a neighbor is shot or a relative becomes a drug addict.

Parents tell of children who cry uncontrollably when they hear gunfire or sirens and who keep the shades drawn in their rooms.

The *Times* quoted a psychiatrist who said: "We're seeing more and more kids who are simply overwhelmed, not unlike people who have experienced shell shock or combat fatigue. They have trouble sleeping, they are distracted. They have panic attacks. They are resigned, distrustful, living for the moment, unable to control their own apprehension."

That's not childhood, it is an extended sentence in a personal hell that these kids did not desire nor create, but in which they find themselves because of the sad circumstances of their births.

Mr. Chairman, our health care system, our drug treatment system, if we can even call it that, and our school system are unprepared for and unable to deal with the crisis of our City's youth.

It is precisely those populations served by our municipal hospital system that are most severely affected by drug use—poor women and children, HIV infected and people with AIDS, and the chronically mentally ill.

Although youth between 12 and 17 make up 20 percent of the State's drug abusing population, only 5 percent of the drug treatment slots are available to youngsters under 21.

New York City birth certificate data from 1976 to 1986 indicate that only 61 percent of pregnant methadone users and 49 percent of pregnant cocaine users obtained any prenatal care.

The most underserved population of substance abusers is young mothers with children. Currently, there is only one residential drug treatment program in the City, run by Odyssey House, that you visited today, that serves young mothers with their children. The only other alternative for these women is to place their children in foster care.

And according to a recent survey, only half of the drug treatment programs in the City accept pregnant women; only one-third treat pregnant women covered by Medicaid, and only 13 percent provide detoxification from crack for pregnant women covered by Medicaid. While there is an overall shortage of drug treatment programs in the City, the problem is compounded for pregnant women who are often times categorically excluded.

Mr. Chairman, the solutions to this complex of problems must be found on man levels—health care, education, employment, law enforcement, individual responsibility and social obligation. But some solutions are so sane, and so self-evident, that we must proceed at once.

Drug treatment must become the highest of national priorities. I believe in treatment on demand, but, in the meantime, before we get there, treatment efforts must be targeted to pregnant women and mothers with children. In fact, an increase in such treatment slots, especially in residential treatment programs, will save us much of the State and local funding we now spend on foster care. It costs $500 a day to provide intensive care for an addicted infant in a City hospital—I take it you saw some today. The cost of caring for a child whose mother is in drug treatment is only $35 a day. Moreover, caring for a healthy child placed in foster care costs $12,000 a year compared to a mother in a residential drug treatment program which costs approximately $16,000 a year, just for the mother alone. It makes no sense not to provide the treatment.

Our senior Senator, your colleague, Daniel Patrick Moynihan, has introduced legislation that would move our commitment a step further. Right now, only methadone treatment is eligible for Medicaid reimbursement as you know. It is astounding but our national health program for indigent individuals does not even cover treatment for cocaine or crack or any other form of drug abuse other than heroin addiction.

This must be changed, and the Moynihan bill would do that by making all crack treatment eligible for Medicaid reimbursement.

Mr. Chairman, we are not yet getting anywhere near the level of help we need from Washington to deal with this situation.

While we are pleased that Secretary Bennett has declared this to be a High-Intensity Drug Trafficking Area and promised a marginally useful amount of additional Federal law enforcement assistance, we believe that such aid should be accompanied by a concomitant commitment to drug treatment.

I was disturbed to read in the last few days that the Secretary seems to think that treatment education is less valuable than some others of us do.

As my good friend the Chairman of the House Select Committee on Narcotics, Charles Rangel, whose Sixteenth Congressional District has said, "While we need to be concerned about the victims of crime, we need to be concerned about the victims of drugs as well."

One thing for sure, these little kinds, I mean, born addicted, didn't do anything to anybody.

We in New York are committed to this effort. At a time when national and regional economic conditions and misguided Federal budget priorities have forced us to cut essential services like fire protection, police personnel, libraries, sanitation and even school programs, nonetheless, the budget I proposed last week maintains our local commitment to drug treatment.

That fact alone speaks volumes about this City's commitment because we believe saving people now will save money in the long run.

Last May, New York City launched a new initiative to expand drug treatment services. The plan proposes to phase in over 21,000 treatment slots during the next 5 years. The plan commits $13.1 million in City funds for fiscal year 1990 and proposed $18.8 million in New York State funds. The Federal share is only $300,000. All told, we will develop 3,200 new treatment slots in New York City over the next year.

Four populations have been targeted for these expanded treatment services: parents in families where parental drug abuse places children at risk of placement in foster care—I would think that it is obvious the reason therefor, the kids go into foster care, minimum $12,000 per child per year; children who are substance abusers—obviously we have got to help them; substance abusing individuals on probation; and expectant mothers at risk of contracting AIDS. The City plans to add these treatment slots through expansion of existing programs and creating new treatment programs.

And lest you think that we are simply spending, you should know that we are embarked on a careful, long-term effort to develop and implement a comprehensive anti-drug strategy.

As we speak, former United States Attorney General Nicholas Katzenbach is hard at work leading an expert team that is re-examining all of our anti-drug efforts and will report back to me by May with recommendations for our overall strategy.

In addition, to all we are already doing, we are now carefully considering a mechanism to ensure that pregnant women have access to drug treatment services. To start, the City, State and Federal government should explore the feasibility of using preventive service funds to provide drug treatment to pregnant women who do not have any other children—given that the newborn child will be at-risk of placement into foster care.

In addition, we need extensive research to determine what works in the area of drug treatment, including a review of alternative approaches such as acupuncture. I visited such a facility late last year at Lincoln Hospital in the Bronx and there a young woman with a child on her lap submitted to treatment, and one or two reporters left, they didn't want to witness this, they were a little squeamish, and he just put the pins in the ear on either side, and she never flinched—apparently it is painless. Mind you, a child planted in her lap as this was going on. They say it works, they say it works. I don't know what the percentage is of curing people, but they tell me it works. Such research should also include a cost analysis of these various treatment modalities.

And finally, substance abuse services should be incorporated into comprehensive community based service delivery systems. A handful of programs around the country that bring together obstetric, pediatric, drug treatment, medical and parenting training services under one roof in order to provide comprehensive care to pregnant and parenting addicts and their children report that this is a most promising approach. The City is considering replicating these programs in communities with the greatest need and we need your help in this effort.

We will continue to study, innovate and act, but one thing I already know perfectly well is that we are committed to this fight, and we hope Washington will join us in this commitment.

National problems require national solutions. We are trying to do our best, but we won't make it on our own.

Thank you for listening patiently while I read all of that.

Senator DODD. Thank you and, Mayor, I know you have a cold.

Mayor DINKINS. You noticed that.

Senator DODD. One thing, just a quick question to you about a personal concern of mine, although I think it is more than just a personal concern. We are focusing obviously on drugs. It is a war on drugs, all of the programs deal with drugs. And yet substance abuse includes more than drugs. I am told that any time you find a drug abuser, you are finding someone who is abusing alcohol, possibly cigarettes and other things as well. Yet, all of the legislation is designed to deal with the drug problem. One of the things I am considering is to modify the titles of these bills and to talk about substance abuse so that we can start dealing with the problem of addiction that the people face in a more comprehensive way. I don't know if you have any comment on that, but it seems to me there is something that we are missing. We are losing a lot more kids on highways.

Mayor DINKINS. Certainly alcohol abuse is a problem as well. We don't have the same assistance in terms of laws there as we do with respect to illegal drug abuse, and I think it is wise to point out that alcohol is as harmful. We don't have prohibition of course but it is wise to point out that it is harmful. I would make this observation, maybe not in direct response to your comment but because I try to remember to say it as often as I can that it was not very long ago that it was the chic in thing to do at so-called Park Avenue parties, wealthy, well educated people, who would try a little coke. When you entered the party, you were told the third door down on the left is where the coke is, so to speak. And, so intelligent, well educated people were dealing in what was deemed to be recreational drugs. We have millionaire athletes and other persons of great wealth and many of whom are pretty well educated—can we not see what happens to young people who have an inability to resist peer pressure that says try it, you can handle it. And, I am told that crack gets to the brain in 4 to 6 seconds, so that is why I disagree with the distinguished Secretary, when he suggested education cannot help. We have got to do all that we can, use of the media, to warn our young people away from the evils of drugs. We have got to do everything, use our collective ingenuity to let them know that drugs kill. A lot of people don't get a second chance. I just see it as vital.

Senator DODD. And I agree with you. I thank you for your testimony. I am delighted to hear you mention the Odyssey House program, which I was very impressed with. I was staggered to find there were 25 beds in the entire city for parents who are abusers, but want to be with their children. Yet, the success rates of a woman in the treatment program who is there with her child is just so much more significant than a single adult trying to wrestle with that problem on his or her own. We know that there are obvious benefits to the child, obvious benefits to the parents. To the extent we can provide some additional assistance to make more of that kind of treatment available, I think we will have greater success. As you point out, it isn't just the mother of one child. Many of these women become the mother of several children and, of course, if you can treat them early, then you avoid the problem of addicted babies repeating itself. Again, I thank you for coming by today, I know how busy you are. I am delighted you brought your two Commissioners.

Mayor DINKINS. These are my experts.

Senator DODD. Mine are sitting behind me.

Mayor DINKINS. It is nice to have experts.

Senator DODD. Thank you Mayor, very, very much.

I am going to introduce our first panel of witnesses and ask them to come and join us here at the witness table. Dr. Jaime Inclan, who is the Director of the Village Treatment Program, New York City. Dr. Inclan will be accompanied by Rodney Williams, a child of a substance abuser. We welcome you and ask you to take a seat here at the table. Jackie McBride is with the Connecticut Department of Children and Youth Services in Bridgeport, CT, and we thank you for being with us. She is also being accompanied by a child of a substance abuser who is now in a foster care program. Ms. McBride will share her observations from 4 years of social work and will cite several cases to illustrate the greater problems experienced by children of substance abusers. Elaine Fitzgerald is a kinship foster parent in New York City and is the foster parent of her drug exposed granddaughter. We thank you for coming as well today. And last is Linda Lemus, who is a foster parent to drug-exposed infants in New York City. During twelve years as a foster parent, Ms. Lemus has cared for 100 children, many of whom have been drug addicted babies. Many of these drug exposed infants were still going through withdrawal and in later years remained developmentally delayed, so we are very anxious to hear her testimony as well.

It is a little crowded up there. This way you all get close to each other and I know you share a lot in common already so again, thank you.

I know that all of you have or almost all of you have prepared testimony. Every single word of your prepared testimony will be included as a permanent part of the record and if it is a little long, I am going to ask you, in order to move things along, to paraphrase your thoughts or share with us, in any way you feel comfortable, your comments that you have prepared for the committee this afternoon. I will ask each of you to comment in the order that I have introduced you so, Dr. Inclan, we will start with you and move right down to the rest of the witnesses.

STATEMENTS OF DR. JAIME INCLAN, DIRECTOR, VILLAGE TREATMENT PROGRAM, NEW YORK CITY, ACCOMPANIED BY CHILD OF A SUBSTANCE ABUSER; JACKIE MCBRIDE, CHILD PROTECTIVE SERVICES WORKER, CONNECTICUT DEPARTMENT OF CHILDREN AND YOUTH SERVICES, BRIDGEPORT, CT, ACCOMPANIED BY RODNEY WILLIAMS, A CHILD OF A SUBSTANCE ABUSER, NOW IN FOSTER CARE; ELAINE FITZGERALD, KINSHIP FOSTER PARENT PROGRAM, NEW YORK CITY; AND LINDA LEMUS, FOSTER PARENT TO DRUG-EXPOSED INFANTS, NEW YORK CITY

Dr. **Inclan**. Good afternoon, Mr. Chairman. I am Dr. Jaime Inclan, I am director of the Roberto Clemente Family Guidance and co-director of the Village Treatment Program. I appreciate the opportunity to share with members of the subcommittee, our comments regarding the current needs in the war against drugs and alcoholism. I can only support, and I will run through and summarize some of the points here because I can only support what our Mayor has just pointed out. He has named the problem and set some of the areas where we need help most.

By way of emphasis, I can only underscore that the New York City and like in all the major U.S. urban centers alcohol and drug abuse is putting in peril the foundation of the Nation by devastating the greatest resource that we have, our youth. The enemy of alcohol and drug abuse is especially intent in destroying our poor and our minorities, African-American and Hispanic youth. Our strategies of combat must include leadership, policy, target communities and funding considerations reflective of this.

There are multiple points of entry for the plague that is alcohol and drug dependency. Sometimes a parent is afflicted first. At other times, a child is. The end result is always the same. The family, our vital basic social unit, is stressed and rendered vulnerable by insidious forces that it is not well prepared to combat alone. Policies and programs must aim at strengthening the life of our families.

Society and government must have the ultimate responsibility tow in this war.

Several points need to be highlighted about this:

The medical, health, alcohol and drug abuse, and mental health systems must be brought together through a unified command structure if we are to fight and win this war.

A unified, program development strategy of care, including reimbursement incentives for such a continuum must be developed. Appropriate services must be provided for the continuum of care options which includes education and prevention.

Our efforts must be targeted. Areas where the enemy of alcohol and drug addiction have inflicted greater damage, taken more of our combatants as casualties or threaten their lives more prominently must receive priority at this stage of the war. New York City and certain regions in our City so demand.

The "civilian population," the private sector must be brought more fully into the war effort. The private sector could be encouraged to provide a much greater portion of the primary care, prevention and education components of the total war effort.

And then the regulatory and licensing processes must be integrated. I was glad to hear comments on this before. It is one big addiction problem. The licensing processes must be integrated and simplified, and financial incentives provided in order to expedite the establishment and utilization of community based programs.

Services again must be oriented to the addicted and his and her family. An over emphasis on service to the victims only, to the addict, will not win us the war.

Additionally, I have some comments here on the mental health implications which I will just summarize.

Children, and I am a psychologist, need their parents to provide for them nurturance, guidance and discipline. The most accurate psychological and emotional index of potential for child neglect and abuse and for an emotionally thwarted personality is the reversal of this relationship. That is, when parents' dysfunctions such as in the addictions, demands that the children meet their needs, or when the demand exists for children to deny their own needs in order to meet those of their parents.

We have observed children in this situation to develop an array of coping patterns that thwart their long-term adult capacity for successful family and social functioning.

We only outlined three:

(1) Some children, following a period of impossible and frustrated attempts to help their parents develop an emotional bluntness—it was also referred to as a noncaring attitude, a sense of defeat and emotional depression. They tend to become the burden and responsibility of the mental health system.

(2) Other children channel their emotional frustrations to affect the environment in aggressive and anti-social pathways. They become primarily the burden and responsibility of the judicial and law enforcement system.

(3) Other children exhibit more transparently the needs for nurturance and acceptance that are masked under their tough skins. These children's needs render them pitifully vulnerable to become victims and targets of sociopathic adults. They are children who do anything for acceptance and approval, and this includes, at some times, giving their bodies and permitting all kinds of perverted social, oppressive or enslaving forms of personal and/or sexual abuse. They tend to float from place to place and become the burden and responsibility of the social welfare system.

Every child is effected. All children with parents incapacitated by alcohol and drug dependence begin life with the odds immensely against them. It is in their cards not to make it. They pay for it with their lives; society pays with money and, more importantly, by compromising its future.

There are, however, true heroes, those who are able to in some way organize their social support and affective network in a manner that permits them a minimum of emotional input, guidance, nurturance and discipline.

With us today is a young man, Rodney, who has been a victim of this war and specifically who has suffered the consequences of having a parent who is addicted to crack. He is here to provide you with some insights about the reality of this underworld.

[The prepared statement of Dr. Inclan follows:]

PREPARED STATEMENT OF DR. INCLAN

Good afternoon. I am Dr. Jaime Inclan, co-director of the Village Treatment Program, member of the Association of Hispanic Mental Health Professionals, and a member of the American Psychological Association Committee on Children, Youth and Families, and the Division of Family Psychology. On behalf of my partner, Mark Wurgaft and I, I appreciate the opportunity to share with members of the Subcommittee on Children, Family, Drugs, and Alcoholism our comments regarding the current needs in the war against drugs and alcohol.

THE WAR

In New York City and all major U.S. urban centers alcohol and drug abuse is putting in peril the foundation of the nation by devastating the greatest resource that we have—our human resource—our youth. The enemy of alcohol/drug abuse is especially intent in destroying our poor and minorities, African-American and Hispanic youth and families. Our strategies of combat must include leadership, policy, targets, and funding considerations reflective of this.

There are multiple points of entry for the plague that is alcohol and drug dependency. Sometimes a parent if afflicted first, at other times, a child is. The end result is always the same. The family, our vital basic social unit, is stressed and rendered vulnerable by insidious forces that it is not well prepared to combat alone. Policies and programs must aim at strengthening the life of our families.

Society and government have the ultimate responsibility to win this war. It must establish and support programs to assist the families, our soldiers in the front lines. Information, education and prevention efforts are basic, and necessary. They constitute boot camp exercises, and should be provided to all. Assistance . . . therapeutic and counseling options must be available on demand to the families fighting this war. Adequate care for the casualties of the war, the addicts, must also be provided. Residential programs, short and long term, and hospitals need to be devoted to the treatment of the casualties. We need to develop a version of the V.A. to attend the full range of needs emanating from the war on alcohol and drugs.

Several points deserve highlight:

(a) The Medical, Health, Alcohol & Drug Abuse, and Mental Health systems must be brought together through a unified command structure to fight this war.

(b) Appropriate services must be provided for the continuum of care options which include education and prevention, support services for children and their families, day treatment and other ambulatory programs, case management, crisis intervention strategies, and an array of residential treatment options that include psychiatric centers.

(c) A unified, program development strategy of care, including reimbursement incentives for such a continuum must be developed.

(d) Our war efforts must be targeted. Areas where the enemy of alcohol/drug addiction have inflicted greater damage, taken more of our combatants as casualties, or threaten their lives more prominently must receive priority at this stage of the war.

(e) Specific resources and time frames for implementation need to be identified and supported.

(f) Through government planning and assistance, the "civilian population," the private sector must be more fully brought into the war effort. The private sector could be encouraged to provide a much greater portion of the primary care, prevention and education components of the war effort.

(g) Regulatory and licensing processes must be integrated and simplified, and financial incentives provided in order to expedite the establishment and utilization of local, community based programs.

(h) Services must be oriented to the addicted and his/her family. An over-emphasis on service to the victim only, the addict will not win us the war. It will perpetuate the revolving door nature of the problem as seen up to this point. Family health is, has been, and will continue to be our guarantee of social stability.

EMOTIONAL CONSEQUENCES

Additionally, in this testimony, we provide some basic insights about the emotional consequences of alcohol/drug addiction from the vantage point of the mental health of the children and their families, specifically about the crippling emotional effects on the life of young children that alcohol and substance abuse, on the part of their parents, causes.

Children need their parents to provide for them nurturance, guidance and discipline. The most accurate psychological/emotional index of potential for child neglect and abuse, and for an emotionally thwarted personality development, is the reversal of this relationship. That is, when parents' dysfunctions, such as in the addictions, demands that the children meet their own emotional needs or when the demand exists for children to deny their own needs in order to meet those of their parents.

When parents are addicted, their money, time, and emotional allocations are deviated from their children to the addiction; children are ignored and left to their own devices. No guidance or discipline is provided. Daily activities and schedules, study time, appropriate nutrition, family time . . . are ignored. Discipline tends to be nonexistent or erratic and capricious, that is, in accordance with the whims and needs of the parent(s) and not as the children and their circumstances demand.

We have observed children in these situations to develop an array of coping patterns that thwart their long-term adult capacity for successful family and social functioning. Here we will outline only three:

(1) Some children, following a period of impossible and frustrated attempts to help their parents develop an emotional bluntness, a non-caring attitude, a sense of defeat and emotional depression. Their fragile egos have been injured, severely and often permanently. Their inability to assist the parent and change the situation is emotionally interpreted as a personal flaw or failure and generalized into a sense of inability to act in the social world effectively. The emotional consequence is blunted affects and depression—the social consequence is an inability to participate fully in family and social life. They tend to become the burden and responsibility of the mental health system.

(2) Other children channel their emotional frustration to affect the environment in aggressive, anti-social pathways. Their underlying depression is acted-out in anti-social behaviors that serve as a defense mechanism that seeks in vain to avoid the psychological trauma of emotional abandonment by the parent. These children evidence "little-adult," gang and anti-social activity early in life, at times as early as 8 and 9 years of age. Without assistance they go on to the hardening of an antisocial character and a lifestyle consistent with the tenets of the underclass. They become the burden and responsibility of the judicial and law enforcement system.

(3) Other children exhibit more transparently the needs for nurturance and acceptance that are masked under their "tough skins." These children's needs render them pitifully vulnerable to become victims and targets of sociopathic adults. They are the children who do anything for acceptance and approval. This includes, at times, giving their bodies . . . permitting all kinds of perverted social, oppressive or enslaving forms of personal and/or sexual abuse. They tend to float from place to place and become the burden and responsibility of the social welfare system.

These are only three prevalent response patterns of children whose parents cannot meet their emotional needs on account of alcohol/drug addiction. Every child is affected. all children with parents incapacitated by alcohol/drug dependence begin life with the odds immensely against them. It is in their cards not to make it. they pay for it with their lives; society pays with money, and more importantly by compromising its future.

There are, however, true heroes, those who are able to in some way organize their social support and affective network in a manner that permits them a minimum of emotional input, guidance, nurturance and discipline.

With us today, is a young man, Rodney, who has been a victim of this war, and specifically who has suffered the consequences of having a parent who is addicted to crack. He is here to provide you with insights about the reality of this underworld.

ADDENDUM

Rodney Williams is a 16-year-old black male who was born in Harlem. Raised by his grandmother and father until the age of five, Rodney's natural mother was not in the home due to alcohol and drug problems. When Rodney was five his father passed away.

At age 14, an adult woman, "Ellen," her husband "Jim" and their 13-year-old son moved into the apartment with Rodney and his grandmother. "Ellen" had befriended Rodney's grandmother as another tenant in their building by the time she lost her own apartment. A year later, when Rodney was 15, his grandmother passed away. Rodney remained in the apartment, now living with "Ellen" and her family.

Over the course of the next year and a half or so Rodney lived with "Ellen," a drug addict who was frequently out of the home. Rodney eventually was able to relocate and live with friends in Greenwich Village. Currently Rodney is once again living in Harlem with a friend and the friend's family. Though in and out of school over the years, Rodney is presently attending school and doing well in the ninth grade.

Today Rodney's natural mother is incapacitated to the point of being confined to a nursing home where he visits her regularly.

Dr. INCLAN. Rodney, how are you?

RODNEY. All right.

Senator DODD. Listen, first of all I want you to know, and I mentioned it in my opening remarks, that we had a chance to meet each other before the meeting began. I always think it takes a special person to come forward and talk about things that are personal. I want you to know, on behalf of the entire U.S. Senate, how much we appreciate your willingness to do this. It is not an easy thing. It is easy to be an expert and come forward and talk about numbers, but to actually come forward and talk about your own life takes a special courage and all of us, and lots of people you will never meet, really appreciate the fact that you have the courage to be here today and to talk about it. I wanted you to know that as well.

Could you give us any general comments you may have about what it was like growing up, what are the problems you see? You have seen some of your friends who may be in a similar situation, what has it been like for them. What sort of things would you like to see happen to change that kind of a situation. Speak right into that microphone, too, so we can hear you.

RODNEY. It was bad, really, because in the beginning I didn't know that the person was on crack. Of course, now I found out she was using drugs for a while, for years, but it got real bad 2 years ago and so she started not cooking and stuff like that, not paying the rent, things like that. Then when I needed something, she wouldn't give it to me. She was in and out, in and out, all times of the night and I was there by myself with her son. We were like sticking together, and we were cooking and doing things like that. She wouldn't care. She would just do as she wanted to.

Senator DODD. So it could get pretty lonely.

RODNEY. Yeah.

Senator DODD. Was it frightening as well?

RODNEY. Yeah, because I don't know—like 1 day she would cook, and 1 day she wouldn't, and she would again, and then she wouldn't for a while. Sometimes I see her, 1 day, then I wouldn't see her again for a couple of days.

Senator DODD. This woman, she was not your mom?

RODNEY. No, she was a friend that we knew for a couple of years and she had moved away from where I lived and then something happened and she lost her apartment, so my grandmother said, "You could stay with us until you find an apartment." And my grandmother passed away and the lady said she would take care of me and everything so we said all right, and then everything was okay for a while. Then, her husband and her started getting into arguments and everything and then he started leaving and coming back and leaving and going and then everything just went downhill.

Senator DODD. It went downhill from there. How are you doing now?

RODNEY. I am doing better.

Senator **Dodd**. What's going on? Tell me where you are now?

Rodney. Well, I am back in school at Seward Park and I am living with my friend Zeke now and his family.

Senator **Dodd**. Is that Zeke out here that I met earlier?

Rodney. Yeah.

Senator **Dodd**. How come he has a red hat on and you have a black hat on?

Rodney. I don't know. I am staying with his family and everything is coming back into place.

Senator **Dodd**. What grade are you in school?

Rodney. Ninth.

Senator **Dodd**. Do you see many drugs in your own classroom, in and around school where you are?

Rodney. No, I don't see it in the school, but around the area.

Senator **Dodd**. You do?

Rodney. Yeah.

Senator **Dodd**. I presume you are going to stay away from that stuff?

Rodney. Yes.

Senator **Dodd**. You have witnessed what can happen haven't you?

Rodney. Yes.

Senator **Dodd**. Thank you for coming here today.

Rodney. OK.

Senator **Dodd**. You stay right there. I appreciate you being up here and speaking out like that.

Ms. McBride, welcome to New York.

Ms. **McBride**. Thank you.

Ms. **McBride**. To Senator Dodd, I would like to extend a thank you for allowing me this opportunity to speak.

When I was first asked to speak to the committee today, my first thought was, "Oh, how do I simplify such a complex topic, a problem that is here in America," and to come up with an answer. The only thing I could come up with is that there is no simple solution to the drug problems here in America, and that the reason for this is that the problem has been ignored for far too long. But, as painful and as hopeless as drug addiction may seem, there can be and are solutions to the problem.

There is no question in my mind that America has a serious drug problem. The American families are in serious crisis. At the root of these crisis is the social disease of drugs and alcohol abuse.

Several parents have given up, thrown in the towel on life and have found comfort in crack cocaine, heroin, alcohol, you name it. Drug abuse is steadily eroding the delicate fiber that has kept families intertwined for many, many years. Our children, their innocence, their abilities are taken away at the moment of birth as they too are now addicted.

Our educational system is vast going downhill. How can our children learn when they are under the influence, hungry, angry and hurting. Our children need our assistance. How can they learn when some of their teachers and principals are under the influence. Our adolescents are confused, frustrated. They have found early utopia in the use of drugs and alcohol.

Some have, because the pain is too much to bear, are taking their own lives, and this is a very, very sad problem here in America that millions and millions of kids every year are taking their own lives. There is something seriously wrong.

They need to know that their lives have meaning. They need to know that life is worth living and that there is a future for them.

We can no longer afford to turn our backs on the problems of substance abuse and alcohol abuse. Substance abuse should not be a second priority, it should be America's number one priority, as it is directly related to America being able to compete in years to come.

Infants, children, adolescents are in trouble because their families are in trouble. They are addicted because their families are addicted.

A week ago today, a 7-month-old baby in New Haven, CT was shot in the head, to his death, and buried the next day. This is a symptom that America is addicted. From letters which take place across the country is also a symptom that America is addicted. College students entering college who can barely write a five-page comprehensive report is a symptom that America is addicted. Mothers abandoning their babies in garbage pails in alley-ways are symptoms that America is seriously addicted.

Who is responsible to see to it that addiction is changed? We are. Every single one of us sitting in this room have a human and a moral responsibility to ensure that children are protected, clothed, sheltered, educated and in good health. Education, health care, homelessness and often social disease of substance and alcohol abuse cannot be treated as a separate entity as they are one. Put parents on the road to recovery and back in the driver's seat, and taking care of their children once again.

It is my hope that this will be the starting point for social workers all around America to get the support it needs to work with our family.

Government must be committed to ensuring the resources are available. Government must begin to channel our tax dollars back into the system. Government must find a balance. It must rework the system of government to secure the state of human existence.

To become a United States again, all systems must work together. Government cannot govern correctly without people. Government must desire to work for people and for the people to ensure that their government provides them with the necessities for survival. We must begin to look at America's drug problems across the board. There is no difference between a drug user and the housewife who is popping Valium, as their addiction promotes the identical problems.

In closing, it is how, that we the people get back to work, we have put in in our taxes. It is time for us to channel our energies in the right directions. It is time for the healing of America's families to begin. Thank you Senator Dodd.

[The prepared statement of Jackie McBride follows:]

PREPARED STATEMENT OF JACQUELINE MCBRIDE

My name is Jacqueline McBride. I am a social worker from the State of Connecticut, Department of Children and Youth Services.

For the past four years I have had the opportunity to work with substance abuse parents and to observe first hand the effects it has on the families I service.

I would like to thank the Senate Committee for allowing me this rare opportunity to speak on what is considered to be a vital issue in this country.

As a treatment worker for the Department of Children and Youth Services, I have had the opportunity to observe and work first hand with mothers and fathers who are substance abusers.

Within the last year, an alarming percentage of the referrals received by the Department are related to substance abuse. The reality of this has increased demands upon social workers to overcome many obstacles and to perform services above and beyond the call of duty.

Children of substance abusing parents tend to have more psychological, emotional, and medical problems than children of nonsubstance abusing parents. On a social level, these children usually have great difficulty developing positive peer relationships. Behaviorally, these children tend to be disruptive and difficult to control. psychologically and emotionally, these children may exhibit anti-social behaviors, depressions, and in some cases suicidal tendencies. Medically, infants seem to encounter the most difficulty. Some of the associated problems are being born drug dependent, brain damaged and testing HIV-positive.

The addicted parent has an entirely different set of problems, making it all the more difficult for a worker to effectively intervene. Most drug addicted parents present problems such as the inability to pay rent and resulting homelessness, as well as criminal activity and the resulting incarcerations, to name a few.

Homelessness is a major obstacle to reunification as it further increases the family's inability to connect and, therefore, inhibits family's ability to function as a unit.

A case in point is that of Miss L. Miss L. is an 18-year-old single parent mother of twins. She has been homeless for over 2½ years. Miss L. has lived with relatives, friends, and, at one point, in a car. To date, this mother is still homeless and is presently living with a relative. Because she and the children are homeless, she has been unable to provide them with needed structure and discipline. As a worker attempting to effectively help Miss L., I ran up against several barriers. Two major barriers were Miss L.'s limited ability to make appropriate judgments. Second, Miss L.'s living with another family made roles of both families become enmeshed. The difficulty with this living arrangement is that I was servicing two families, as opposed to one.

Another difficult aspect of working with addicted parents is that of denial. During denial of the problem, parents refuse to take the first steps toward recovery. That step being to acknowledge the addiction and to make a plan to do something about it. Even after receiving a positive assessment that they are drug and/or alcohol dependent, they will not follow through on necessary treatment. I would never want to believe that drug addicted parents are hopeless, but there is a level of realization that some addicted parents will remain abusers for the rest of their lives.

Case in point: Mrs. G. has been in three different inpatient treatment programs. She recently left her fourth inpatient treatment program after she had only three more months to go for completion. The pattern thus far has been that she goes in and will stay clean for a few months, maybe a year, and then the drug and alcohol use will resume. Perhaps the one ray of hope at this time is that Mrs. G.'s children were removed and the possibility of their not being returned may be the boost to make her commit to leading a drug and alcohol free lifestyle.

Another obstacle, and what is also considered by some to be an addiction, is domestic violence. It is considered addictive in that it is a learned behavior, and to some extent, acceptable. One must always keep in mind that what triggers domestic violence is the addiction of the abuser.

A classic case is that of my client Miss M. Miss M. is a 30-year-old single mother of four. As a child she was physically and emotionally abused by both parents. According to Miss M. her father would beat her mother every time he drank; she and her brother and sisters witnessed the beatings. When Miss M. developed relationships with men, she, too, found herself locked into violence. Added to the violence is Miss M.'s current addiction to alcohol and sporadic use of crack.

Other programs that provide services to addicted parents seem to create yet another thorn. Most of the problem with drug treatment programs is that they, too, are overloaded. Which means, if I were to get my client to the point of acceptance to get help, they would have to wait. It is during this waiting period that all the efforts put forth may crumble by the wayside. Addictive personality persons have very low tolerance and, therefore, will give up very easily.

Finally, as we near the end of the 20th Century and embrace the last decade of it, we are faced with AIDS. The most devastating reality of this social disease is its clinch is rapidly destroying the lives of infants. A more frightening reality is that an increasing number of adolescents are diagnosed HIV-positive. Today's adolescents are supposedly tomorrow's leaders, but several will not live to see the year 2000, and among African American males, several will not see 1990. This pace is a sad, but real, reality to social workers. As a worker you must constantly keep adolescents pointed in the right direction as they are quick to runaway and may disappear for days, weeks, and sometimes years. The danger is that in order to survive, they will engage in prostitution (both male and female), experiment with drugs, etc., which increases the likelihood of their becoming infected.

Infants, children, and adolescents "are in trouble because their families are in trouble". They are addicted because their families are addicted.

TREATMENT/PREVENTION EDUCATION

Foster Care

The biggest improvement needed in this area of foster care are increased funds as an incentive to recruit more foster and adoptive homes. Increased funding would also help to train needed foster families who will provide care for these children.

Specialized foster homes and training are needed to provide homes for infants who are born drug addicted and HIV-positive.

Within the health care arena, there is a need for them to come together to develop a more comprehensive method in providing medical services to high risk infants and children.

For African American children, a specialized group should be devised to recruit foster homes and adoptive homes. One such program expected to be implemented, which is a step in the right direction, is the One Church, One Child Program. If successful, this concept can become the cornerstone to developing other methods of recruitment for African American families.

Services in the Home

Services for families in crisis need to be provided in the home or in closer proximity to the home. My feeling is that people respond much better when they are not forced to give up their privacy or individuality. Since the problems are in the home, being able to work them out in the environment gives parents the control needed to rebuild or to build structure and set boundaries for themselves and their children. People need help but they are not completely helpless, is the message programs of this kind can promote.

Inpatient Treatment Program

Without question, more facilities to provide inpatient treatment is needed. Again, making these programs available in closer proximity of the community will increase the likelihood of participation. The incentive of this type program is that if children must be placed temporarily they will not lose contact with their parents. Moreover, development of new facility will decrease the waiting period for treatment programs.

Outpatient Treatment Program

Once addicted personality persons have completed inpatient treatment, the temptations to resume substance abuse is possible. Outpatient facilities should be readily available to them. Keep in mind that substance abuse is a lifelong illness, which means there is no cure but there is a cure to treat the desire and the symptoms of the addiction.

Another benefit of outpatient programs is that parents are able to be reunified with their families and members of the family can be a part of the treatment progress.

Homeless

One needed resource to decrease the number of homelessness is affordable housing and improved shelter conditions. Affordable housing should not be limited to one condensed area of a city, it should be throughout.

There is a great need to improve the physical conditions and the locations of shelters. Several of the available shelters are housed in inadequate buildings. The furniture, amount of privacy families have, and sleeping conditions are some of the drawbacks of shelter living. The surrounding environment or the location of shelters all induce the sense of hopelessness.

EDUCATIONAL IMPROVEMENTS

Children from troubled families are prone to several disruptive behaviors. The acting out behaviors children exhibit are usually coded social maladjusted by the educational system. Teachers need to have a clearer knowledge to understand children who come from dysfunctional families. Moreover, the educational curriculum should provide improved preventive education and provide alternative vocational programs to children at risk of dropping out of school.

SOCIAL WORKERS/COUNSELORS

There is a tremendous shortage in the number of qualified social workers and drug/alcohol counselors. Workers who are qualified are overworked to the point of burnout. As an incentive to attract qualified workers, increase in salaries should be offered. Increasing the number of social workers and counselors will help curve case overloading and free workers up to provide services on a one-to-one basis. I firmly believe that a skilled worker must understand human behavior, be aware of available resources that are available to substance abuse clients, have a sound educational knowledge in the area of addiction, and be committed and empathic to working with addicted parents. These skills will dramatically improve the quality of treatment services.

IMPROVE PROGRAMS FOR CHILDREN AND ADOLESCENTS

As a social worker and a single parent, I am very aware that good support systems from extended family members, friends, and the community helps to limit some of the amount of stress parents have in raising children.

Afterschool programs can act as a surrogate extended family as it can provide children with structure and consistency needed on a day-to-day basis. Moreover, afterschool programs can improve peer relationships with children and take away the boredom children feel when there is nothing to do. In addition, it will teach them life skills which will help to increase competency, self-esteem, and to tap into their creativity. Attached to these programs should be regular involvement of parents. Parent support groups, parent-child activities, etc., as this will enforce and strengthen the idea of family togetherness.

In the African American communities children need positive role models, especially young African American males. Each program should ensure that African American young men be included in the development and implementation of afterschool programs.

Addiction is a serious and real way of life for several families in America. We can no longer afford to ignore the problem or treat it as a secondary priority. Substance abuse and alcohol abuse affects people of different ages, races, socioeconomic standing, and religion. As a social worker I observe first hand the ill effects that addiction has on mothers, father, and children. I would sincerely like to improve and promote positive changes in the lives of my clients, but in order for this to occur, government must be committed to ensuring that the resources needed to make changes are available. More importantly once government makes prevention education a priority on their agenda, social attitudes about this issue will certainly change for the better.

Respectfully submitted, Jacqueline McBride, Social Worker, Department of Children & Youth Services, 1115 Main Street, Bridgeport, CT 06604

Senator DODD. Thank you very much, Ms. McBride. Lisa Williams is here with us as well.

Ms. MCBRIDE. Yes.

Senator DODD. And Lisa we welcome you and thank you for coming down from Connecticut. I know you are in a foster care program now, is that correct?

Ms. WILLIAMS. Yes.

Senator DODD. I wonder if you might just tell us a little bit about yourself, maybe you can pull that microphone over so we can hear you. Like Rodney, we are grateful to you for taking some time and sharing with us your particular personal experience. Why don't you tell us a little bit about yourself?

Ms. WILLIAMS. Hello, my name is Lisa Williams, I am 18 years old. At the age of 15 I was brought into DCY's care, the Department of Children Youth Services. My mother lost our apartment. She could not pay the rent. My first placement was at the Greenwich Youth Center for 1 month. After a month, I went to Job Corp. for 8 months. I felt that my mother was not doing her job as a mother.

I do not respect my mother as a mother, but even though my respect is not there for her, I still love her. While living with my mother, I ran away many times. I ran away because I was getting beatings with extension cords and broomsticks. I feel my mother was under a lot of stress and this was her only way to take it out, it was on me.

My father lives in South Carolina and at one point in my life I wanted to live with him, but now I understand that his drinking would get in the way of my living a good life.

At this point in my life, I would like to pursue my GED so I can go into the Air Force. I feel that in spite of the problems I have had in my past, I can go on and make a life for myself and be happy. Thank you.

Senator DODD. Thank you Lisa. What would you recommend? I mean, what would you tell young people today or others about the dangers of substance abuse—people who may be in your situation? What would you say to them?

Ms. WILLIAMS. Well, I would just say that—to always have a positive attitude toward anything. There is a solution for every problem and there is help for almost everything.

Senator DODD. Do you have brothers and sisters?

Ms. WILLIAMS. Yes, I have one brother.

Senator DODD. Older or younger?

Ms. WILLIAMS. Older.

Senator DODD. Was it frightening for him as well growing up?

Ms. WILLIAMS. Well, I felt that him and myself have a fear of losing things so every other month he is in jail, he just keeps on going back to jail. Since my mother lost the apartment, I just had a fear of getting an apartment and losing it, or losing things period, and I think he feels the same way.

Senator DODD. That you won't be able to hold onto anything, do you think you are going to end up leading the same life your mother did, is that a fear you have?

Ms. WILLIAMS. That is a fear, but I am trying to get a positive attitude toward not feeling like that.

Senator DODD. Well, that's good. Lisa, thank you for coming down here and sharing with us your experience as well. How old are you now?

Ms. WILLIAMS. Eighteen.

Senator DODD. From your experience, is there a lot of increased drug activity in the last few years that you have seen?

Ms. Williams. No, my father introduced marijuana to me and his reason for introducing it to me was so I won't find out in the street and just be blown out of proportion. So, that is the only drug I have ever used.

Senator Dodd. In retrospect do you think that was a mistake on his part?

Ms. Williams. In a way I kind of accepted it because this is my father looking out for me.

Senator Dodd. But you wouldn't recommend that as the normal?

Ms. Williams. No.

Senator Dodd. OK, thank you for coming.

Our next witness who is with us is Elaine Fitzgerald. Elaine, we thank you for coming out here today and being with us. We are all anxious to receive your testimony.

Ms. Fitzgerald. My name is Elaine Fitzgerald and I am a foster parent. One of the children I have is my granddaughter, the other one is my niece. The only one I am going to speak on is my niece.

I received her in September of 1987 and she has been in the system since 1987. I have not been able to get any type of help for her, medically or otherwise and this child is drug addicted. I was not aware that this child was drug addicted when I received her. One night at about 2 o'clock in the morning, the baby started shaking, screaming and crying. I had no idea as to what was wrong with her. I had to take her to the Emergency—in the emergency room I was almost arrested. I had no papers to prove that I had this child because no papers were given to me when she was brought to me. They called the police—it was like I had done something wrong. This child is drug addicted and I am supposed to know this.

When they all finished and I tried to explain in the best way that I knew how that the child was brought to me by two police officers and that the papers would follow soon after. Well, papers never followed, Medicaid never followed, reimbursement never followed, a social worker never showed up, there were no court dates, there was nothing. There were no diapers, no formula. I don't know what I am giving this child, how do I take care of an infant, what kind of milk am I giving her, what kind of medication is she on. Does she need vitamins, what does this child need to survive?

But, I continued to take her back and forth to the doctor and that was all at my expense, which was not my biggest problem. If I have to pay, fine, then you have to pay, but somewhere someone has to be made aware that when these children are brought to you, at least tell you what kind of formula the child is on, the child's date of birth, when the child was born, where the child is born, what is wrong with the child, is there a defect, what is going to happen in later years with this child, where do you take her, who do you call for treatment, who do you call to notify when this child is sick? The baby needed surgery because there was something wrong with the toe. I have no one to call, I have to take this child, this child has to have this surgery or the child is not going to walk.

Afterward I notified the agency that this was done because it was done on a Sunday. Who do you notify on a Sunday? There is no one to notify and if you call you are told the worker is not in, call back later. Can I leave a message? Sure, you can leave a message. No one ever gets the message. You get the surgery done and you sign and you are told that you can be brought up on charges because you signed for this child and you have no legal right to sign for surgery to be done, because you are not the child's guardian, the commissioner is and only the commissioner has this authority. So, where is the commissioner on a Saturday or a Sunday? You are the one that is responsible for this child, because that child is in your home, and if you don't get it done, you are the one who is at fault, because if you get it done, you are guilty, if you don't get it done you are guilty. So, where do you stand, what do you do? Where is the answer?

You can't get anything. I have had this child for 2 years and I am still waiting. I am waiting for a Medicaid card. I received a Medicaid card on November 1, 1989, it expired November 1, 1989. OK, and I have the cards. They expired the same day I received them. So that is not doing me any good, it doesn't do the child any good.

The next thing is that all of a sudden this one child—the mother appeared 3 weeks ago. I got a call that in 5 minutes, I have to have this child to the agency because the mother wanted to see the child. Meanwhile, for 2 years, there is no parent, and you have to take this child there, because if you don't you are going to be arrested, and this is what I was told over the phone and I said that the baby is sick, she can't come out, it is snowing, she cannot come out in the weather. "That is too bad, her mother is here." Well, where was her mother when she was sick, shaking, crying and has to go back and forth to the doctor? The mother is not there because the mother is on crack, the mother is by herself, the baby is here. What do you do? Where are the answers?

Right now this baby goes every other week and it started out that she was on Tylenol every 4 hours because she was going through withdrawal. She has a rash over her body which occurs—it goes away, it reoccurs. Her hair is not growing and it is all due to the addiction.

What do you do about it? Where do you go? Who is going to help because the workers do not help you, they don't help at all. They hang up the phones on you, they don't do anything. If you call the supervisors, they don't help, they relay the message. God knows if they relay it and don't go to the Center because no one knows anything and no one has anything. I do work and therefore I pay $60 a week for a babysitter. I am told that they have provider mothers that you can get help. If you fill out the form and you go up— it is by Parkchester in the Bronx so if you go up there, you fill out the form, you have priority. That is not true, you don't have priority. You wait like everybody else. And when they do finally find you, after 2 years, I have one, but I have to go ten blocks out of the way to get her there. That is ten blocks to go and ten blocks to come back. Never mind that I have one that I have to get in school. And you must have these kids picked up by 6:00, that is fine. But they tell you 8:00—you bring them at 8:00 and you pick them up by 6:00. But, you are ten blocks out of the way. There is no way that you should have to go that far to take a child.

If you are going to help, then there has to be a better way of helping. I also have a 9 year old. Now, both of these children have asthma, both parents were drug addicted. One is my daughter. All right, the 9 year old is my grand child that her mother is my daughter. The 9 year old tells me that her mother was doing something, but she didn't know what, but when her mother had company, she had to go into a closet or she was going into the bathroom and going underneath the sinks. She was screaming, she was yelling. And no one is doing anything. I called PCW myself in the beginning to have the apartment investigated. But the first thing they asked me was, "Did you see her doing it?" I don't see her do this and you wouldn't see yours doing it. But this child is telling me that and when a child tells you something, you have to at least check it out. My granddaughter used to pack her clothes up and leave and come to my house. She didn't have far to go because I lived next door to her.

And when I received her I explained to them that she is a severe asthmatic and that she is. And now every time she sees her mother or her mother calls, when she gets finished you can believe I have to take her to the doctor. It is like there is something triggering this child off when she sees her mother. She does very well in school, but if she goes and visits her mother, the next day you can believe that she has reacted and the teacher is going to call.

Her mother was in a program out on Roosevelt Island somewhere and I was ordered to take her out there and I refused to take her out there, because I know what it does to her when she goes out there. But, the worker came and the worker took her out there. When she went to school that Monday, I had the teacher call the worker, because this occurs each time that this child goes. When her mother ran away from the treatment center, I was told that I still had to let her visit with her child. I am not saying she doesn't have a right to see her child. She came to see her child, when I asked her that it was time for her to leave, she would not leave. She pulled a knife on me, my back was turned, she tried to cut me, she was unable to succeed because I have a 21 year old there also. Since she could not do that, she proceeded to take my chairs to my dining room set and she threw them off of my cat walk. Well, better to throw the chairs off the cat walk than to do something to me.

Right now, my 21 year old lives in a fear and I live in the fear that they are going to take the kids away from us, because every time I get a call on the job it is because, first of all, where I was living prior, they told me that I didn't have enough room for the kids, there was no heat, there was no hot water—which was not my fault, I am paying my rent. It is not that I didn't pay my rent. My rent is paid. When you gave me these kids you knew I had two bedrooms. Now that is not good enough for them. So, you are going to take them away from me. So I will move. I moved from paying $225 to $727 to get three bedrooms and all I am asking for is medical help and I can't get medical help? You don't get medical help, you don't get a crib, you don't get clothes, you don't get Pampers, you don't get anything and you are not even told what this child can eat and what she can't eat, you don't even know the formula.

What do you do? Where are your answers? I mean, everybody has answers, but no one has the answers to those questions, because I have called all over Albany, I have called everywhere, and all you get is I will get back to you. The only person who ever got back to me was from Senator Dodd's office. No one has gotten back to me and I am waiting. This was September 16, 1987, 2 o'clock in the morning, and I am still waiting for them to get back. I am waiting for the diapers, I am waiting for the crib, I am waiting to be told what type of formula I am supposed to be using.

Finally, last year, I got a check for $5,000. The $5,000 would not put a dent in her medical bills. The medical, paying a babysitter and buying clothes and seeing that this child goes to the doctor whenever she has to go. It is not easy.

The foster parents catch hell, excuse my language, but we do, and once they find out that you are related, forget it because you are in trouble. You are supposed to—I had one tell me that I am supposed to do it, that I am responsible for them. I am only responsible for what I had and I took care of what I had. But, yet, I am responsible for them now because they are in my care and they are in my home. And I take over 4 days out of a month because these children must go to the doctor. One has to go for breathing exercise. The other has to go because she has to be treated because she was drug addicted, and this is an ongoing process. Yes, the baby was tested for HIV. So far, it is negative, but she must be tested again in 5 years. These are things that they have to address. I understand that medical is very important. So, you don't want to give the money, fine, give the medical. Medical costs more than anything else out there. I started out paying $65 a visit. The next time I went it was $90. Now, when you go, it is $100 or $125 and depending on the test that is running, it can cost you anywhere from $300 to $400. Still, there is no Medicaid.

The baby is lost in the system. They don't know who had the case before. I can tell you all of the names. They don't care. The workers, half of them do not care.

[The prepared statement of Elaine Fitzgerald follows:]

PREPARED STATEMENT OF ELAINE FITZGERALD

I am currently the foster parent for my granddaughter and my niece. Both are in my care because their parents have used drugs. It is my niece, Chasity, who I want to tell you about today. I've gladly taken responsibility for her, but the city foster care agency hasn't been much help.

I received Chasity Simmons on September 16, 1987, at about 2 a.m. She was three weeks old. I was told at that time that someone would come to my house during that day to give me the money or necessary things to care for Chasity. I didn't see a worker until Friday, September 19, 1987. At that time, she brought 2 receiving blankets, a sweater and hat, 2 undershirts, and promised to work on getting the crib and other supplies. No one ever came to my house to see Chasity or inquire as to her care, until April 1989.

During this time, about 2 weeks after I received Chasity, I took her to Columbia Presbyterian Hospital Emergency Room for constant crying, shaking, and a rash that wouldn't go away. I found out that Chasity was a drug withdrawal child and needed much care. Chasity could not keep food down. Several formulas were tried, all at costs beyond my means.

I called the worker to explain the situation. I needed to get a prescription filled and had already paid for Emergency Room care. I was then told to bring prescriptions to the worker, so she could check as to their cost and then get a voucher for moneys to give me. I was unable to leave my job at the time to get to her office and go through that procedure, so I purchased the medication myself. Chasity's needs came first.

Chasity developed a sore or blister on her toe and was again taken to the Emergency Room. She required minor surgery under local outpatient care. This incident occurred on Sunday. I was unable to reach the social worker, but spoke with two different supervisors. One of them told me I had no right to sign for surgery, but how could I not let her walk? I also asked for a Medicaid card because Chasity would require ongoing care and I was unable to pay for each visit and medicines. There was no response to these telephone calls at this time.

I called an emergency number in Albany and was given the telephone number of an official in New York City, Mr. Ponds. I then explained the entire situation to him, asking for assistance both financial and medical. After this call, a worker came to investigate my home so I could be certified as a foster parent. She then called me at my job to notify me the children would be removed from my home, because I didn't have heat or hot water. The case was brought before a judge, who denied her request. The boiler in the building was broken and not my personal fault. This judge also ordered that I receive assistance to help with the care of the children. This happened in December, 1987.

I was not notified again, nor did I get any assistance. I called Mr. Ponds, the emergency contact, in January, 1988 to bring him up to date. I was then contacted by the child welfare agency and went to classes to become a foster parent. I eventually received $5,000 from the Child Welfare Administration, but with no explanation of what it was for.

As of April 1989, I was notified of a new worker for Chasity. She has come to my home, but has yet to get me medical assistance (Medicaid card). She has me come to her office to make personal requests for temporary Medicaid cards, which only last 2 weeks. This is supposed to activate a permanent card, but hasn't of yet.

To date, Chasity has medical appointments for a constant rash, a weak muscle in her left eye, and general care. I have not received any support for crib, clothes, hospital appointments, medicine, or a current and useful Medicaid card. I am employed and also must pay a babysitter. I was told I would be reimbursed, but I have not been given these moneys either.

I am not asking for these things for myself, but for the children. I have had to make financial sacrifices and have seen other grandparents in similar situations. In addition, it is very painful to see what is happening to the parents of the children in my care, including my own daughter.

Foster parents also need more help from the agency asking us to care for children. I believe parents receiving foster children should get some kind of start-up kit, consisting of 1 crib, clothes, bottles, pampers, and medical assistance to care properly for these children. It would also be helpful to have a worker's name and telephone number to be in contact with for follow-up information and correct instructions as to foster parent duties. All of us who are caring for children of relatives want to take good care of them, but we can't do it alone and need support.

Senator DODD. Elaine, I may have some questions here for you in a minute. I appreciate your testimony. I will come back with some additional questions for you, but we will give Ms. Lemus a chance and then we will come back and go into some questions.

Ms. FITZGERALD. I'm very sorry sir, but when I——

Senator DODD. No, no, I appreciate it. It is very helpful to hear what you are going through. I admire the fact that you have taken those children on and you have done so well with them.

Linda, we thank you for being here as well this afternoon and are happy to receive your testimony.

Ms. LEMUS. Thank you. My name is Linda Lemus. I am a foster and adoptive parent. I have been a foster parent for approximately twelve years and I have nurtured over 100 children.

I am not going to read off this testimony, but I noticed everything that has been said, if I repeat it, what parents need for their children, would just be repetitious. We all know what they need: housing, education, drug treatment programs.

So my focus is going to be on the foster parent, the forgotten parent. The parent who dedicate their lives to these children, nurture them, love them, and then when their biological parents come back, are told, "You must give these children up."

We are the forgotten parents. We choose to do what we do out of our love and commitment to the children of the City. The problem is that when our Mayor sits here and says, "Foster care, $12,000 a year," that is fine and well. I understand politics you need numbers, but the reality is that we are not numbers. We are not $12,000 a year. We are families. We are not group homes. We are people who have had our children, have raised them and have nurtured them, and have chosen to take on the children as what we call them of adversity. The children whose parents have been addicted by this system of lack of heart, love, and whatever it is, poverty, drugs, and substance abuse.

I am the woman who gets up in the middle of the night and walks the floor for hours because the baby is trembling, because the baby is throwing up, because the baby does not move. I am the one who walks the floor with the baby attached to my body. All I simply want to say is that foster parents deserve respect. We are not $12,000 a year, we are people, and we contribute a lot to this society.

There is an estimated 50,000 children that are entered in this system by June 1990. And, although we need these preventive services and our dream, our goal as foster parents is to reunite these children to their biological parents, but, when the biological parent is ready and able to care for them—that the programs that are so often talked about are put into place so these children go home to a safe, loving environment, not to be returned into the foster care system, battered and abused and sometimes killed, which is a reality that we have to face. Too many children are getting hurt because of the name "biological".

How many chances do we give a biological parent before their rights are terminated? How long do we go on? Five years, 6 years, 7 years. That is something that has to be addressed.

Once they receive the services and those children continue to come back into the system, there has to be a cut off point so that these children can be freed for adoption and, if they do return into the foster care system, a mechanism where the previous foster parent and that child will be reunited. They are all the same children bounced through the system. Yes, they do, not so much because foster parents don't want them, but we simply don't know when they return into the system. So, there has to be a way of reuniting these children when all else has failed with their previous foster parents. People who are considering adopting them. Yes, give the biological parents community drug treatment programs, treatment on demand, mother residential drug treatment programs where they can take their child. But, you have to say, "When does it all end? How many times do we do this?"

The Mayor referred to CWA as Special Services for Children. As foster parents, we have always said special services for parents, because sometimes the children's rights are not—it is the most important issue—it is the parent's right.

As this grandmother has said, Elaine, yes, CWA does not provide services for these children. There goes a long period of time, 18 months, 24 months, where children do not have Medicaid cards, you don't even have the information that you need to get these children the kind of services that they need once they are placed in your home. We have children coming into the system with contagious disease such as lice, scurvy, and we are families. These diseases are transmitted to foster parents and their biological children, and we deal with this. For the meager $12,000 a year that we do receive.

I know there has to be a better way and we all want our children to grow up with their parents, but there is a time when we as a society have to consider what is also best for the child. Once we have met the needs of the parents, we must look at the child. You cannot allow a child to linger in foster care for 3 to 4 years, 5 years, and then say it has to go home with mommy. That child does not know who that mommy is, so you have to move these children out of the system with more speed, which means getting these programs into place, but also recognizing that it has taken a long time for these families to be destroyed and it is going to be a long time to put them back together, and we have to consider what this time does to the children in the foster care system as well as their foster parents.

The way the system is now, it serves no one. It doesn't serve the biological parent, it does not serve the foster child, and most certainly it does not serve the foster parents who give their time, their energy and their homes. I thank you.

[The prepared statement of Linda Lemus follows:]

PREPARED STATEMENT OF LINDA LEMUS

Allow me to introduce myself, my name is Linda Lemus, Foster and Adoptive mother. I also represent New York State Foster and Adoptive Parent Association Inc. as their Legislative Chairperson. I have been a foster mother for twelve years, within that time I have nurtured over one hundred foster children. The ages of my foster children range from 0 thur 11 years of age. All of the infants I have cared for have been drug addicted babies. In the last six years I began to observe a difference in the babies entering my home, 9 out of 10 of these babies were still demonstrating signs of drug withdrawal when they were placed in my home. These children after a period of four to five years are developmentally delayed, to what degree depends on the child's history and severity of the mothers substance abuse.

The challenge before us today is to try to find solutions that will enhance the lives of these children and their families. Poverty and substance abuse must be addressed. These families must be provided with: 1. Affordable housing, 2. Comprehensive Services, 3. Community-Based Services, 4. Drug Treatment programs upon demand! and 5. Residential treatment programs for women with their children.

These are just a few suggestions to help keep families together and prevent foster care placement. These are the goals of foster parents that every child would be nurtured by their biological parents in an affectionate and secure home, but the sad truth is that an estimated 50,000 children are predicted to enter the foster care system by June 1990. The reality is that it has taken many years of neglect, poverty, and drugs to destroy these families and it will take, in several cases, just as long to rebuild these families. In some cases the children will never be reunited with their biological parents. This is why we must retain our foster parents, they are the future adoptive parents. In numerous case, the only hope for a promising future for the various children in foster care.

EXAMPLES OF CONCERNS AND ISSUES

Children are being placed in foster homes with medical forms that workers say are cleared for placement. However these children are sick, illnesses range from high fever, scabies, lice, asthma, sexual abuse and gonorrhea. these illnesses are not reported to foster parents before the child is placed. Misinformation of this nature can result in a serious tragedy. Foster parents must be informed, this will enable them to provide the quality care that is essential for our children.

Foster parents require the understanding that they are partners with staff and administrators in providing services for their children, that their input is valued and that it affects decisions, not only should they be invited to attend meetings regarding the future of their child, but urged to do so. This kind of communication is essential in providing the case worker with an understanding of the child's special needs. The information that only the foster parent can provide.

Many foster parents show immense efforts to help the children and the public should be made aware of the needs of the cities foster children. Public awareness is essential of the volunteer (Not Paid) nature of foster parents efforts. Qualified foster and adoptive parents should be invited to serve on boards and committees that are formed by Child Welfare/Protective Services, Local and State agencies, as are other respected members of the community.

Honesty from the agency in all matters concerning the child/children, will give the foster parents the proper tool to obtain the vital services necessary for our children within the community. This assistance will allow the case workers, the essential time to attend to urgent business. Example: Home visits to evaluate how the children are progressing, paper work, training, court proceedings.

The availability of funds to provide quality training to foster parents concerning special and exceptional needs children is not being met. The mandate issued by the State regarding the placing of no more than two children under two years of age in a foster home is a policy that should be reevaluated. The determination should be based on the support system and the experience of the foster parent. This reevaluation will prevent the loss of cribs and beds now in use. Home-maker services can be utilize to assist foster parents with more than two infants this will insure additional cribs and is cost efficient.

A clearly defined appels procedure needs to be initiated and widely publicized, for serious grievances. The opportunity to assist in the retention of foster parents by the encouragement only ones own peers can bring forth positive change.

Respirte is needed from the pressures of foster care, whether for a day, weekend or time off between placements when burout is evident. Respite service will provide the foster parents the time they need to rejuvenate, and in many cases avoid placement disruption. Acknowledgment of the fact that a foster parent has the right and at intervals must decline to accept a particular child when the family determines they lack the proper training to care for that child. Agencies must respect the families decision and refrain from harassing the foster family when they decide not to except a child.

All agencies should encourage and support an active Foster and Adoptive Parent Association. Where the communication with experience foster parents can and do provide a significant measure of support and training for new foster families. Foster parents should be allowed the benefit of the doubt, when there is an allegation of abuse or neglect in the foster home. Recognizing that the foster parent/family "is innocent until proven guilty," to often the treatment many of our foster families receive while under investigation can be expressed by the saying "guilty until proven innocent." Biological parents, when reported for mistreatment, are afforded every opportunity to disprove life threatening abuse, neglect, or undesirable conditions, should foster parents not be provided at least the equivalent opportunity.

Foster care literature and the continuing pre-service training should be furnished. Speak of partnership between agencies and foster parents. Key terms such as "Team" and "Colleagues" are becoming more common. Agencies which have developed an environment of mutual respect between workers, administrators and foster parents, are becoming notable for understanding one another's role, accomplishing critical longevity of foster families. Reducing dishearten feelings of foster parents and providing the services they need to care for their children, may well be the greatest contributor to a successful "Retention and Recruitment" program.

I would like to express my appreciation on behalf of Dora Diggs, executive director, Ida McMicheals, president and the members of New York State Foster and Adoptive Parent Association Inc. We hope this information we have shared with you today, will provide an indisputable understanding of the difficulty encountered by the foster parents in a year proclaimed the Decade of The Child.

Senator DODD. Thank you very much Linda, and all of you, for your testimony. Let me just address a few questions, if I can, to each of you. Dr. Inclan, you indicated that you felt there was a need for a greater continuum, a better strategy. I wonder if you might elaborate on that a little bit, give some specific examples of what you feel needs to be done in order to provide for that continuum of care.

Dr. INCLAN. Well, we need crisis intervention services beginning with the hotline services and crisis intervention services where people can access assistance and referral assistance immediately. We need your primary care alternatives. I think the private sector can be much more encouraged to participate in the delivery of this kind of care. Programs on an out-patient basis needs to be established where people suffering from any of the addictions and their families can participate in a program of rehabilitation, and then, of course, we need all the way up through the rehabilitation in the programs—the long-term programs and interim programs. And I think that enveloping all of it, we need a massive education and prevention program. As I shared before, it is very clear to us from the study of families, that it is very simple what children need. They need guidance, they need education, they need discipline, and they need parents who can provide that. When parents can't provide that, whatever the reason is, be it mental illness, be it social inadequacies or be it by suffering out of the addictions and when that formula is reversed, as I have seen some testimony here, then the children need to be referred for themselves or look after some of their parents needs. We have trouble in the form of mental illness brewing for them. So, we need all of those alternatives.

Senator DODD. Let me ask you this. A lot of people have told me today before coming to the hearing that we are on the verge of losing a generation or we already have lost a generation or possibly even losing a second generation, one person said. That is a pretty bleak analysis. I have always believed that children who were given love and some care even though they may have had some dreadful experiences have a great deal of resiliency. Rodney and Lisa here had tough experiences growing up, but they seem to at least believe there is some hope around the corner and have a positive attitude. Are they really a lost generation or am I correct, is there resiliency there?

Dr. INCLAN. I believe that "loss" is a strong word. I don't think we would be here if we really thought that. I think there are more people who would concur with you, who try to document that. I think what is important is to see what are some of the ingredients that made those mistakes, I mean, what we have learned here, so much with Rodney, whereas it was Papa John—where is Papa John? Papa John is an elderly figure in the community who was taking him in and provides him guidance and counseling. Dr. Rinaldo Ramos and his wife, a fellow psychologist who identified Rodney who lived in the Village who happened to know the family. They provided a lasso, a bridge, a hand. They have pitched in independently collaborated to provide for one young man, inexperienced, with some guidance, some support, some orientation and I think that that is a key ingredient. I think we see it repeatedly and I think the people are there willing to—the parents here who have testified that in their own presence and those of others who they speak to that they are willing to do what it takes. If they can recognize them and support them, acknowledge their work.

Senator DODD. I appreciate that. Ms. McBride, you talked about more in-home services and more social work staffing. I want to talk about the importance of the in-home experience. That is something we are going to take a closer look at. We see residential programs, we see a lot of out-patient treatment programs, but to get to an in-home setting, I think has some very positive potential benefits and could help reduce costs. People are more comfortable, react better in that environment. I wonder if you can elaborate on how you think these services should be provided.

Ms. **McBride**. One such program that we have in Bridgeport right now that recently started about 4 months ago is called a Family Preservation Program, and this program has, I think, a staff of about 3 or 4 workers and these workers go into the home with the family on a day to day basis. It is a very intense work with the family. They provide the family and connect the family with resources. They sit down if there is a crisis, because they are there on a daily basis, and what they tend to do is to try to come at a time when the crisis seems to be at a really high time, and usually it is sometimes in the morning, it may be before nighttime going to bed where it is hard to get the kids to go to bed, or whatever time of the day it is really difficult. And we are providing them with the services and the resources—you are there, you are right there showing them step by step by step, this is how it goes. The advantage to that is that you don't lose the bonding, children do not lose the bonding that they have with their parents, and I think one very important thing that we cannot forget is that children, in spite of all of the bad things that they have gone through with their parents, they still love their parents, and it is documented that many of them, after very bad experiences, later on in life, go back out to seek that parent. So, I think that it is worth us trying to try to keep the families together and I think with home based programs, that is it.

And a part of that also is programs that are readily available right there in the community, that you don't have to go ten miles, you don't have to go and spend X amount of money to get to it. It is right there in the community, community centers, that can provide some family support groups, activities for children, which is very important. I see our youth gets into a lot of trouble because there is nothing for them to do. When you come home from school and all you have to do is play Nintendo and run around, I mean, that is a lot of idle time. I think what is happening to some of their interests is some of their creativity is a way to stop them from going out into the streets and getting into the same way.

The other half to the question that you asked me was of the social workers, and I don't know—in New York, I can hear that you are having a real tough time and I know in certain places in Connecticut it is also tough, but I know that with social workers, there are days you are really stressed out. I mean, there are problems, problems are heavy duty. I think that the one thing that needs to happen is that foster parent social workers all need to understand that we are all human beings and that we have limitations and that we work in a very complex system that requires us to be the outlet, the ending to these children. Yet, you still—we are all paper pushers. We have to push out these papers, we have to document, we have to show that this is happening, we have to do court petitions, we have to ensure that these programs are here making referrals, so there are times that you may not get to your children and spend the time that you need with them one on one. There is not enough time in a day so therefore you need to have extra people to work with you. We need extra income for the workers there. I mean, it is not an incentive to come to work and listen to problems all of the time and really—they are really stressed out, and then get a paycheck and it is nothing. So, I think, as an incentive, it will help to see that there is more money put into this and I mean for workers to be more qualified, to know what they are doing, to work with families, to be empathetic and to really authentically care for people. I think that is important and I think in spite of the fact that the money is not there, I think that workers—I can speak for myself, I really authentically care for people, and try very hard to work closely with my clients, but there is a need for more workers and for more funding in that area, to recruit more workers.

Senator DODD. Let me ask both Elaine and Linda, since you are foster parents but under different sets of circumstances, I am interested in knowing how this works. Did either of you ever receive any training or instructions from the Child Welfare Agency about caring for drug exposed children?

Ms. LEMUS. Well, Elaine is a kinship foster parent because she is related. I am a recruited foster parent because the children that come into my home are not related to me. We have training from the agencies. There are a certain amount of it—20 to 30 hours of training. The problem is that the children that are coming into the system now, these high risk babies, we don't get the training that we would like, such as CPR, such as early childhood intervention where we would take the children to learn how to exercise and how to massage them and all of this. They don't provide that. The training is very limited. Constantly foster parents are complaining that they do need more training for these children because these high risk babies, a lot of them tend to just stop breathing on you when they come in. They are placed from the hospital and all of a sudden they just stop breathing.

Senator DODD. But you didn't get drug related training, you didn't get anything?

Ms. FITZGERALD. No.

Ms. LEMUS. No, no drug related training, no.

Senator DODD. What sort of training did you get?

Ms. LEMUS. Separation and loss, when a child comes into your home and it is taken away from its parents. Basically that was it, separation and loss, agency rules and regs——

Ms. FITZGERALD. Right.

Ms. LEMUS. That's it.

Ms. FITZGERALD. I am just going to add to what she said, besides behavior and what you can and cannot do with the child. You cannot beat the child, you cannot take the television away from the child. No matter what the child does, you cannot touch this child nor can you take television privileges—no discipline is allowed to be done to this child.

Senator DODD. Now wait a minute, there has to be a distinction here—I mean, the child isn't going to run the home.

Ms. **Fitzgerald**. The child is, according to them, because you cannot discipline this child. You cannot hit this child.

Senator **Dodd**. Well, hitting the child is one thing.

Ms. **Fitzgerald**. But you cannot take the television away, you cannot take the toy away, these children cannot be punished at all, and these are kids that are just coming out of school that are teaching you and telling you what to do with the child and they are doing it from textbooks.

Ms. **Lemus**. No corporal punishment, that is what we are——

Senator **Dodd**. Well, I understand that.

Ms. **Lemus**. Recruited foster parents are told there is no corporal punishment and we get training on—they give training to parents on different techniques to discipline a child. That is No. one, so I don't know about kinship because they are different workshops—kinship and recruited.

Senator **Dodd**. Elaine, your particular case has been widely publicized. There is a *New York Times* article about your particular situation and it was reported that City officials at the time were having some second thoughts or reservations about allowing relatives to become foster parents. I am wondering what your thoughts would be on how you balance that responsibility that you feel as a grandparent or aunt in the case here, with agreeing to become a foster parent as such and accepting the kind of restriction that a recruited foster parent like Linda, next to you, would be involved in. You are both foster parents, but that is where the similarities end. You are a grandparent of one of these children, you are an aunt of another. Yet, you are taking on a foster parent obligation. It seems to me it is getting kind of confusing when you have that blood relationship and yet that foster parent responsibility. How do you reconcile that in your mind? What are your thoughts on that generally—do you think it is wise that grandparents or blood relatives can become foster parents as well?

Ms. **Fitzgerald**. Yes, I do, and why I say that is because we are closer to the children, at least I am, and the children then is a part of your family and they become your family and they are your family and you put aside the fact that this is a foster child, this is not a foster child, this is my child, this is my granddaughter, this is my niece and right now they are my children.

Senator **Dodd**. Well, you had the problem of your daughter, I guess it was, with potential violence?

Ms. **Fitzgerald**. Yes.

Senator **Dodd**. Now, Linda is that a problem—have you ever faced that with 100 foster children? Did you ever have problems with the natural parents?

Ms. **Lemus**. No, I don't have problems with the natural parents because it is a different setting. They are not relating to me, they do not have my home address, they can't—I am not so readily available to them as a mother, an aunt a grandmother would be.

Senator **Dodd**. I see.

Ms. **Lemus**. And our visitations are done at the agency. Now, we have the option to meet with the biological parent which I like to do because most of the time they have information which would help me with the child. But, also, it is a different setting so there is security there, you know, and some times you run for your life and sometimes you just say, you have to think real quick on your feet if they do get potentially violent, but it would be a shorter span for us because it is the setting, whereas, in the home, it can go on indefinitely. In the agency, we have the security when it does get there, so it is a little more safe for us I would say.

Senator DODD. Do you have much contact with your daughter, Elaine?

Ms. FITZGERALD. No, I don't. I don't have contact with her and before I moved I did, after I moved I was to have no contact. If she wanted to see the child, she would have to make arrangements through the agency, but someone conveniently, in the agency, gave my daughter my address and my phone number. She had no idea as to where I had moved.

Senator DODD. Let me ask both of you as well as you, Doctor Inclan, and you, Ms. McBride, this question. I was stunned this morning to learn the statistics. I guess it was last year or the year before—don't hold me to the year—but the increase in the number of foster care placements for this City was around 12,000 or 13,000. By the middle of this year, there will be in the neighborhood of over 50,000 children in foster care, with considerable strain on the system, I am told. There have been all sorts of options considered including going back to the notion of the 19th Century, early 20th Century, orphanages and so forth, because of problems with where to place children.

Obviously, I think the better environment clearly is a foster care environment—well, obviously, the best environment is with the natural parent where the things are healthy and the things are working well. If you can't have a child with a natural parent, then the foster family home environment is best—whether it is the grandmother, the aunt, or a recruited person. Obviously my guess would be the closer the person is to you, blood-wise, that is a preferable setting at least normally, one would think. And the worst of all circumstances would be an orphanage kind of an environment, I would think. What sort of thoughts do you have—any of you here—on how to cope with this problem of trying to get more people to become involved in foster care as we see no short term abatement of these numbers. Also crack is a broader problem, as you see more mothers abandoning children or you find the problems associated with living with a substance abuser, such as Rodney's experience, not with his mother but with the woman he was living with. Why don't we start looking at some answers here that make some sense to you? If all of you could quickly answer—Doctor, do you want to begin?

Dr. INCLAN. Programs in the community, I think, here we have seen the Committee for Hispanic Children and Families have begun to establish some programs to meet these needs and I see that their report to me is that they are getting very, very good results. Education campaigns, meetings in the community, talking to the parents—you would be surprised how people will tend to come forward and respond when the information is made available and the people are motivated, so I think we have to go to the communities and talk to the parents and the natural leaders and older people in the communities, and provide them with some sense of the problem and the incentives, both in human terms, first and foremost.

Senator **Dodd**. Getting people to come forward and take on the foster care?

Dr. **Inclan**. Yes they tell me that their experience is one that is beginning to yield good results. They bring people out and they present them with the problem and begin building a network so I think you have to go to community for support.

Senator **Dodd**. Ms. McBride?

Ms. **McBride**. Well, I agree with you Doctor, that you should go to the community. The other half to that is that I feel that for the amount of money the foster parents receive, it is a real smack in the face——

Senator **Dodd**. It is a real—?

Ms. **McBride**. It is a smack in the face that they do need the extra finances to provide for these children. They are taking care of these children on a day to day basis. The other half is that they also need support systems. They need to know that if I run up against a problem, where can I go for the support system? Where do I get the support? There should be a number readily available for her. A 1-800 number, that I can call this number 24 hours a day so that I can get some form of assistance and I think that if we are asking people to take care of children, especially high risk children, that we are going to have to add some incentives as well as some real support systems for them.

Also, as I said before, the in-home treatment program, that will hopefully help to reduce the amount of children that will go into and come into the system, and there are some cases where placement necessitates placement, but I think that if we really try to work with families, really, really try hard to work with families, provide them the services, make available to them the services in their communities, make it in their homes, it will help those that are going to come into the system.

Senator **Dodd**. OK. Quickly Elaine and Linda, any thoughts on this?

Ms. **Fitzgerald**. Well, the only thought that I have on that in trying to make this work and to get other people to take the children is that they have to be honest with us. They have to be honest with the foster parents. Don't make promises that you cannot keep and if you bring the child—at least if you bring the child on a Thursday, if it is an infant, bring the necessary things that the parent needs to take care of this child. If it is an older child, bring whatever is necessary. When you bring these children to us, you fail to bring us clothes, you fail to tell us what schools they go to, what grades, no date of birth, there is no data with them. You have to have something.

Senator **Dodd**. Linda?

Ms. **Lemus**. I believe that what foster parents need is information as she was saying—support systems. I also believe in each agency there should be a foster parent association of experienced foster parents like myself who train new foster parents coming into the City. Foster parents themselves are your greatest source of recruiting new foster homes because we are in the churches, we are in the buildings, we bring in perspective new foster parents. Services, yes, the City must provide the services such as Medicaid cards, community services, evaluation for the children. We need leadership, quality leadership. I don't mean just people up there, figureheads, I mean people who know what is going on with their foster parents and could implement programs that are truly going to help the foster parent help the child. And, also, those programs for those biological parents so that the children can be returned to their biological parent as soon as possible or be freed for adoption.

Senator DODD. Very good. I want to thank all of you, you are very patient in taking all of those questions. And a special thanks to Rodney and Lisa for being here as well. We thank both of you very much and wish you both nothing but good fortune in the future and a lot of happiness in your lives, too. So good luck to you, too. I thank all of you for coming here today. You are more than welcome to stay and listen to our last panel.

As our first panel is leaving, let me introduce the last panel this afternoon. Doug Besharov is a resident scholar and director of the Social and Individual Responsibility Project for the American Enterprise Institute. We appreciate your being with us today, you are very thoughtful and patient. I am honored to present as well Judge Herbert Barall, a superior court Judge for the State of Connecticut who has seen a lot of pressure on our juvenile court system over the last number of years. Dr. Loretta Finnegan is the director of Family Center, Thomas Jefferson University Hospital in Philadelphia, PA, and will describe a program which provides intensive medical and psychological services for drug and alcohol dependent women with specialized care for those who are pregnant. Ira Marion is the associate director, Division of Substance Abuse at the Albert Einstein College of Medicine here in New York. We are pleased as well—is it Dr. Marion or Mr.?

Mr. MARION. Mister.

Senator DODD. We appreciate your being here. I am very grateful to all of you. We are running a little behind here in our time this afternoon, that is my fault. I get interested and want to hear more. I hope some of the testimony you heard was interesting to you, sometimes that is the case as you are waiting to go on yourself. I am going to ask you to try and keep your remarks under 5 minutes if you can and the full testimony will be put in the record. This way we can get to a few questions and engage in discussions, so just highlight the comments to help us move along. We will begin with you, Doug, and follow along in the order that I have introduced everyone.

STATEMENTS OF DOUGLAS J. BESHAROV, RESIDENT SCHOLAR AND DIRECTOR, SOCIAL AND INDIVIDUAL RESPONSIBILITY PROJECT, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC; THE HONORABLE HERBERT BARALL, JUDGE, SUPERIOR COURT, HARTFORD, CT; DR. LORETTA P. FINNEGAN, DIRECTOR, FAMILY CENTER, THOMAS JEFFERSON UNIVERSITY HOSPITAL, PHILADELPHIA, PA; AND IRA MARION, ASSOCIATE DIRECTOR, DIVISION OF SUBSTANCE ABUSE, ALBERT EINSTEIN COLLEGE OF MEDICINE, BRONX, NY

Dr. **Besharov.** Senator it is a real pleasure to be here. What I will do is just summarize some of the findings from a survey that we at AEI conducted with the American Public Welfare Association and then make a few remarks about it.

We found that over a 24 month period, between June of 1987 and 1989, the number of children in foster care rose from 280,000 to 230,000 nationwide and I think we have made reference to some of these statistics. That is really a striking increase and that amounts to 17 percent. If we try to extend quotas that quickly in any other area, we would see the tensions that would develop.

Public welfare authorities are estimating that the increase will rise to 360,000 by this June. That will be a total of an almost 30 percent increase in the period of time we are talking about, 80,000 children total.

It is so hard to get a handle on what we want to do about this problem, and I think especially if I could take the opportunity to encourage you and the other members of the Congress to think about problems of foster care that you have heard about and child protection in a different way then they have been thought about in the past. We have spent 15 years trying to fix foster care by junking it, that is to say, we spend a great deal of time and a great deal of energy on what is called permanency planning, services for family preservation—all very important and all having had made a very positive contribution to the field. But, in the process, we have neglected the nuts and bolts of the foster care system and I think you have heard some of that today.

The analogy I will draw is a little by like a jalopy. You have a jalopy and it needs new brakes but you decide that you are not going to keep the jalopy so you don't invest in the brakes. But, we have assumed that we will get rid of foster care so we haven't invested in the technology of counting children in foster care, and providing training to foster parents and we were prudent in supervising children in foster and, yes, eventually in removing children from foster care and getting them placed for adoption.

I would say to you that without denigrating any of the family preservation activities which would be encouraged and continued, it is time to invest in that set of brakes for the jalopy because foster care is going to be with us for a long time and the drug epidemic is just the newest burden put on American children. It is just the newest reason why there will continue to be large numbers, tens of thousands, hundreds of thousands of children in foster care, so, what we are already doing is, again, without reducing family preservation efforts, is fixing the conditions of foster care so that these things don't happen and in providing financial and procedural incentives through Federal law so that States will both be able to move more of these children into permanent foster homes and eventually, if necessary, into adoptive situations.

I can be more detailed later with you.

[The prepared statement of Dr. Besharov follows:]

PREPARED STATEMENT OF DOUGLAS J. BESHAROV

Mr. Chairman, members of the committee, thank you for inviting me to testify before you on this important and troubling subject.

I will focus my remarks on only one aspect of this multifaceted problem: the effects of parental use of crack and other drugs on state and local child welfare programs. First, I will share with you the results of the initial phase of our just completed national survey of state agencies which found that, in a 24-month period, the number of children in foster care has increased by almost 30 percent, from an estimated 280,000 children in 1987 to an estimated 360,000 today. I will then discuss how this unprecedented increase in foster care poses both moral and administrative challenges to child welfare agencies and to society as a whole.

Crack and Child Welfare

Children are the most heart rending victims of the current drug epidemic. Each day, about 100 babies are born who have been exposed to crack and other drugs before birth. Tens of thousands of older children live with their drug addicted parents in deplorable conditions. Drug czar William Bennett called these children "the worst casualties" of the nation's drug problem.

Although other drugs have plagued our society, most users have been men. Crack, a derivative of cocaine, has changed this pattern. For the first time, there are large numbers of female addicts, many of whom have children or are pregnant.

Crack is a different kind of drug, too: It is a mean drug that induces some parents to incredible violence. In one widely reported case, a five-year-old girl was found dead in her parents' apartment with a broken neck, a broken arm, large circular welts on her buttocks, and cuts and bruises on her mouth. Her nine-year-old brother was found the next day huddled in a closet. Both his legs were fractured; he had eight other broken bones, and bruises covered his body.

Children who are not physically assaulted may be victims of their parent's neglect. "People who start using have got to find that money. Children aren't being fed," says Maurice Macey, western regional manager for Missouri's Division of Alcohol and Drug Abuse. "Mothers sell their food stamps. Young women sell their bodies, and that's done in front of the children. Even when heroin was at its worst, it wasn't like this—it wasn't openly done." In one case, a 10-month old died after being left overnight in an overheated room—the temperature reached 110 degrees—while his mother visited her boyfriend.

(I describe these and other cases in an article that appears in the current issue of *Public Welfare* magazine, a copy of which is attached.)

Concerned about the increase in such cases, the American Enterprise Institute, the American Public Welfare Association, and Abt Associates obtained funds from the U.S. National Institute of Justice to conduct a nationwide survey of state child welfare agencies to gauge the impact of substance abuse on child protective and foster care programs. We have just completed the initial phase of our survey, and I am pleased to release our findings publicly—for the first time—to this committee.

Our survey of all 50 state child welfare agencies reveals an unprecedented surge in the number of children removed from their parents and placed in foster care. APWA estimates that, in 1987, there were about 280,000 children in foster care; today there are about 360,000. That's a 29 percent increase in just 2 months—and the numbers are still rising. See Tables 2 and 3. (For your reference, I am enclosing a memorandum summarizing these data from Toshio Tatara of the APWA to Mr. Larry Guerrero and Dr. K.A. Jagannathan of the U.S. Department of Health and Human Services.)

Between 1986 and 1989, an estimated 80,000 children were added to the foster care population. However, the increases have been quite uneven, as you can see from Table 1. The communities hardest hit by crack addiction have experienced startling increases. Two states (California and New York) were together responsible for 55 percent of the increase. California's foster care population rose 41 percent during this period, from 47,327 in 1986 to 66,763 in 1989. In New York there was an increase of 90 percent, from 27,504 children in 1986 to 52,189 in 1989. (The increase includes children placed with relatives, about 10,000 children.)

Today one out of three foster care children comes from either California or New York, although fewer than one out of five American children live in these two states. In 1986, the ten states with the largest foster care populations accounted for 55 percent of the national foster care population. Now roughly two out of three foster care children in the country reside in these ten states: California, Florida, Georgia, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, and Pennsylvania. Georgia's foster care population rose by 43 percent between 1986 and 1989. Illinois, Massachusetts, and New Jersey also experienced large increases in their foster care populations.

In states without a serious drug problem and in those that have not responded to the need, foster care statistics have remained flat. Washington, DC, I am afraid, is in the second category. Part of the explanation is money. Foster care, especially for these children who often need special treatment, is expensive, and the District of Columbia seems determined to save money by ignoring the plight of these children. Earlier this year, nurses at D.C. Children's Hospital notified the District's child protective agency each of the two times that a one-year-old child was sent home after testing positive for PCP, and both times he was returned to the hospital with a higher level of drugs. Typically, the District's Child Protective Services agency will not become involved unless the mother abandons her newborn.

Table 1

Children in Foster Care (1985-1989) ¹

(Based on the last day of the reporting period)

State	FY 86	FY 87	FY 88	FY 89
Alabama	4,337	4,390	4,417	
Alaska	1,232	—	—	
Arizona	2,434	2,641	3,008	
Arkansas	1,321	1,032	1,077	
California	47,327	51,821	62,514	66,763
Colorado	3,100	2,941	2,881	
Connecticut	3,530	3,370	3,631	
Delaware	763	696	698	
District of Columbia	—	2,120	2,210	
Florida	6,802	7,017	7,725	7,544
Georgia	9,311	10,356	11,597	13,325
Guam	—	37	39	
Hawaii	1,267	1,423	1,400	
Idaho	756	1,307	770	
Illinois	14,472	15,829	17,425	19,296
Indiana	4,730	5,207	6,043	
Iowa	3,579	3,856	4,012	
Kansas	4,203	4,277	4,443	
Kentucky	2,863	3,235	3,232	
Louisiana	6,717	6,717	6,097	
Maine	1,855	1,835	1,815	
Maryland	5,198	5,470	5,868	
Massachusetts	7,546	8,814	9,588	10,284
Michigan	8,566	9,791	11,302	
Minnesota	5,616	5,924	5,900	
Mississippi	2,219	2,587	2,702	
Missouri	6,554	6,515	6,902	
Montana	—	—	—	
Nebraska	2,438	2,432	2,296	
Nevada	1,876	1,264	1,590	
New Hampshire	—	1,264	1,44[illegible]	
New Jersey	6,597	8,681	8,542	8,798
New Mexico	2,062	2,088	2,195	
New York	27,504	29,197	45,746	52,189
North Carolina	6,254	6,124	6,126	
North Dakota	587	540	589	
Ohio	11,966	11,263	12,539	14,200
Oklahoma	2,075	2,048	2,217	
Oregon	3,250	3,623	3,885	
Pennsylvania	14,685	13,433	14,636	15,416

Table 1—Continued

Children in Foster Care (1985-1989) [1]

(Based on the last day of the reporting period)

State	FY 86	FY 87	FY 88	FY 89
Puerto Rico	2,252	——	——	
Rhode Island	2,085	2,293	2,569	
South Carolina	3,692	3,563	3,583	
South Dakota	547	461	446	
Tennessee	4,409	4,590	5,077	
Texas	4,727	4,769	5,449	
Utah	1,132	1,176	1,118	
Vermont	1,025	987	1,025	
Virginia	5,902	5,898	6,011	
Virgin Islands	——	——	——	
Washington	5,789	5,632	5,725	
West Virginia	——	1,955	——	
Wisconsin	4,833	4,826	5,018	
Wyoming	595	608	762	
Totals:	272,380	287,973	325,885	207,815

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[1] State foster care populations for fiscal years 1986, 1987, 1988, and 1989 based on VCIS data collected by the American Public Welfare Association.

Table 2

Estimated Yearly Increases (FY 1986-1989)

Year	Estimate	% Increase from FY 86
FY 86	280,000	——
FY 87	293,000	+ 4.6
FY 88	330,000	+ 17.9
FY 89	360,000	+ 28.6

Table 3

Estimated Increases in Selected States (FY 1986-1989)

State	% Increase
California	41
Florida	11
Georgia	43
Illinois	33
Massachusetts	36
New Jersey	33
New York	90
Ohio	19
Pennsylvania	5

FOSTER CARE LIMBO

There are many levels of drug use and, media coverage notwithstanding, some drug-using mothers can care for their children adequately, at least with social service support. In recent years, we have learned a great deal about working with abusive and neglectful parents; programs across the nation are helping many thousands of parents, including those who use drugs, to take better care of their children.

Uunfortunately, nationwide, there is a severe shortage of drug treatment programs, especially for women; most programs have long waiting lists, and many do not accept pregnant women or mothers. These conditions have lead to calls for an expansion of treatment programs for drug-using mothers and women in general, which I certainly support. However, expanded treatment, no matter how richly funded, will not be the total solution to the problem. For, even the best programs have only modest success treating hard-core addiction.

What we cannot do for crack addicts in general, we cannot do for addicts who happen to be mothers. Hard-core crack addicts are exceedingly difficult to reach. "To get off drugs one must be motivated by love or dedication to something greater than personal pleasure or pain," explains Edwin Delattre, Bradley Fellow in Applied Ethics at the American Enterprise Institute. "But the circumstances of these young people—without education and opportunity—thwart the formation of such motivation and this, plus the intense pleasurability of cocaine, makes successful treatment almost impossible for many addicts."

Years of effort have yielded no widely applicable therapeutic program for treating heroin addicts. The only practical treatment for large numbers of these addicts is methadone maintenance. No similar "blocking" agent for cocaine has been found, although there have been some initially promising experiments with anti-depressants. Years of work, however, will be necessary to see whether these drugs, or some new approach, will work. "Crack is new enough that no one has yet figured out an effective treatment according to Peter Reuter, a Rand Corporation expert on drugs.

Thus, for the foreseeable future, we must be prepared for the reality that agencies will have little or no success in treating heavily addicted parents. And we must likewise be prepared for the reality that the children of these parents, again, not all children of drug-using parents, but those of parents with serious problems, must be placed in foster care.

Despite recent media publicity about the foster-care crisis, the vast majority in the system receive good physical care, often substantially better care than their parents can provide. The problem lies in foster care's emotional impact. Children who stay in foster care for more than a short time, especially if they are older, tend to be shifted through an unsettling series of ill-suited foster homes, denying them the consistent support and nurturing that they desperately need. These problems are magnified for the children of addicts.

Because their home conditions are usually so bad and treatment has only limited effect on their parents, once placed in foster care, these children of crack tend to stay there. In New York City, 60 percent of the babies discharged from hospitals to foster care—mostly crack babies—were still in foster homes three years later. Of those in foster care, more than half (56 percent) had been in two or more foster homes; 20 percent had been in three or more homes. One child had been in eight homes.

Foster care was designed to be a temporary remedy used only until parents are able to care properly for their children. Today, foster-care procedures are still designed to reunite families as soon as possible. This important goal can be carried to extremes, however: In one case, an infant who was discharged from a six-month foster care placement and returned to her mother and grandmother was found four months later to have serious burns on her back, possibly made by a clothes iron. The child was immediately returned to foster care. Subsequently the mother admitted using crack to her social worker, and six months later, despite being enrolled in a drug treatment program, she gave birth to a baby with symptoms of cocaine addiction. Yet the agency's goal was still to return the girl, by then almost three years old, along with her newborn sibling, to their mother.

Many judges and caseworkers would place more children of addicts in foster care, but they believe that the emotional limbo of foster care can be as harmful to these children as living at home with their drug-using parents. They reason that many children, after years of unsettling foster care, will end up back at home with those same parents. In effect, these professionals are choosing between two harmful situations and deciding that many children would be better off in the care of addicts. But there are other options.

The Moral Challenge: Adoption

Increased adoptions by loving adults is one route out of foster care limbo. unfortunately, current legal rules and agency policies make it exceedingly difficult and time consuming to terminate parental rights. As a result, fewer than 10 percent of the children in foster care are put up for adoption.

Even in the most alarming cases, few children are quickly made available for adoption. One crack baby was placed in foster care after his father killed the boy's baby sister. The mother, who was frequently beaten by her husband, was in touch with the foster care agency only sporadically. Three years later when she gave birth to yet another cocaine-exposed child, the first youngster still lived in a temporary foster home.

The growing foster care population of crack children is forcing a fundamental reexamination of the state adoption laws. Most people seem to agree that adoption laws need to be changed to reflect the realities of drug addiction, to make adoption a real option for children whose drug-addicted parents, usually mothers, cannot care for their children and who show little prospect for improvement. The question for legislators is: Where to draw the line?

Making it too easy to terminate parental rights would be as harmful as current policy and would face legitimate opposition. What if, for example, a drug-addicted parent is willing to accept help but the help available is ineffective? Or worse, what if there simply is no treatment at all?

Many of these mothers are barely more than children themselves. Usually poor and seeing little prospect for the future, they are, in a sense, themselves victims of extremely difficult circumstances. It is discomforting to take such harsh action against those young mothers who are trying-albeit unsuccessfully—to improve their troubled lives.

Moreover, even though there are many more potential adoptive parents than casual observers believe (there are waiting lists to adopt spina bifida and Down's syndrome babies, for example), some foster children—older or handicapped—are not readily adopted. For these children, terminating parental rights is not freeing them for adoption but, instead, cutting the last tie to their biological family. This is particularly troubling because, in time, some parents will conquer their drug problems.

The issue of race also heightens our unease. Drugs, and especially crack, take their greatest toll on those least able to bear the burden—members of disadvantaged minorities. In California, for example, for the first time in that state's history, the absolute number of black children in foster care exceeds the number of whites, even though less than 10 percent of the state's children are black. A tough policy for taking children away from parents that falls most heavily on minority communities should make everyone think twice.

These considerations are largely mitigated when a parent is offered a reasonable program of treatment and flatly refuses to accept help. Thus, it seems appropriate to amend state laws to encourage adoption in such cases—especially for young children. Whether more ambiguous situations will also be made grounds for terminating rights will be determined after a spirited debate about the rights of children versus the rights of parents. As my previous remarks suggest, I believe that a moderate loosening of adoption laws is long overdue, but, as I have also tried to suggest, there are important competing values at stake.

In any event, even under the most liberal adoption law conceivable, many children of addicts will continue to live in foster care for long periods, so we should also be working to give them as normal a life as possible.

The Administrative Challenge: Better Foster Care

Foster care must be restructured so that it can provide the kind of nurturing care children need. This means stable care over the long term.

The first priority must be to have the highest quality foster parents. Most agencies, however, are having difficulty recruiting high-quality foster parents and have been forced to modify their criteria for foster parents. Many, for example, now allow single women who work full-time to be foster parents—even though they have to hire others (usually without agency supervision) to care for infants and toddlers.

Although the worsening physical and behavioral problems of foster children is one reason why it is so hard to attract new foster parents, simple economics is a more serious obstacle, and one more amenable to solution. In many places, payments to foster parents have not kept pace with the inflation of the last decade. Even when they have, agencies must compete against the marketplace for the mothers who were once their prime source of foster parents and who are now increasingly in the paid labor force. If we want to attract better foster parents, we will have to pay them more than $4,000 per child per year, the approximate national average.

Giving long-term foster children a sense of constancy must be the second priority. One idea being considered by many states is called "permanent guardianship." In this arrangement, the child is placed with an individual willing to accept permanent responsibility for the child's upbringing. This new guardian has all the legal rights of a parent (the agency is no longer involved) but the parents are able to maintain contact with the child. This has proven to be especially helpful in cases where the child is older and the placement is with a relative or a long-term foster parent who has developed a relationship with the parents.

When on-going support from the agency is needed, perhaps because the child has severe handicaps, some states allow the child to be placed in a status called "permanent foster care." This gives the child a constant and secure home but allows the agency to stay involved.

Placing children with relatives is another solution to the shortage of good foster parents. In New York City, almost one in three foster children are in the formal care of relatives, who are receiving full foster-care payments.

The advantage of all these new arrangements is that they avoid a complete break in family ties. But that is also their most serious disadvantage. Relatives sometimes return children to their parents without telling the agency, either out of fear or solicitude. Non-relative foster parents sometimes refuse such arrangements because they do not like the idea of having a drug addict involved in their lives. Clearly, more study and experimentation will be needed.

Some commentators have called for a return of the orphanage. For older children, some sort of small congregate care arrangement, like a group home, makes a great deal of sense. For infants and younger children, living in a home and family setting is best, and it ought to be our goal.

Meeting these twin challenges will not be easy. Making it easier to terminate parental rights is sure to be controversial, and may come only with the active support of the disadvantaged communities most affected. Similarly, the restructuring of foster care into a long-term, supportive environment will require a level of administrative commitment and capability that has too often eluded foster care agencies. But if we are to meet the needs of crack children, we cannot avoid facing these issues.

MEMORANDUM

TO: Mr. Larry Guerrero
Dr. K.A. Jagannathan
FROM: Toshio Tatara
SUBJECT: Estimates of National Child Substitute Care Populations: Advance Information
DATE: October 16, 1989

I am writing this memorandum because I would like for you to receive this information first. Later on, I will have to share the information with some key state people.

Judging from statistics that are available from major states, it appears that there has been a substantial increase in the national child substitute care population in the past few years. VCIS is currently gathering FY 87 data substitute care and adoption, but I have gone ahead to try to collect state foster care information for some key points in time—beyond the FY 87 period. Presented below is a summary of what I have learned:

—Although still tentative, our estimates of the national child substitute care populations from FY 86 to FY 89 are:

Year	Estimate	% Increase from FY 86
FY 86	[1] 280,000	
FY 87	293,000	+ 4.6
FY 88	[2] 330,000	+17.9
FY 89	360,000	+28.6

[1] VCIS has already published this figure.
[2] Very tentative but a "conservative" estimate. It may be revised later.

—Between FY 86 and FY 89, a total of about 80,000 children were added to the substitute care population. It appears that two states (California and New York) were together responsible for 55.2 percent of this increase during the same period. The State of California experienced an increase of 41.1 percent and the State of New York 89.8 percent, since FY 86. The substitute care children of these two states now account for about 33.0 percent of the national substitute care population. This means that one out of three foster care children today comes from either California or New York. This percentage was 26.7 in FY 86.

—In FY 86, the ten states with the largest substitute care populations accounted for 55.3 percent of the national substitute care population. But by FY 88, their share increased to 66.1 percent, and it is assumed that the percentage is even higher today. This means that roughly, two out of three foster care children in the country reside in the following ten states: California; Florida; Georgia; Illinois; Massachusetts; Michigan; New Jersey; New York; Ohio; and Pennsylvania.

Experts attribute these sudden, huge increases in the number of substitute care children in mostly urban states to the dramatic increases in the incidence of substance abuse among adults and the resultant increases in the number of the so-called "cocaine/crack babies." In a separate effort, I have tried to collect state statistics for the number of "cocaine/crack" children coming to the public child protective service (CPS) system, but attempts have not been successful because only a few states gather such statistics.

If you have any questions about the information presented in this memorandum, please call at (202) 682-0100. Thank you.

Senator DODD. No, that is helpful and I noticed in your release as well that those alarming statistics, New York and California had about 55 percent of that increased explosion in population in those two States. Taking a particular look at New York and California as to what is happening there that is a good indication of what we could face in other parts of the country, as those two States seem to be trend setters in both the good and the bad things.

Dr. BESHAROV. Unfortunately, as an ex-New Yorker, I can say that is true.

Senator DODD. The order I am following here, Judge, you are next and again we thank you for coming down from Connecticut today. I hope we haven't exacerbated the backlog of superior court cases.

Judge BARALL. Let me tell you what my responsibility is first. In addition to being a superior court judge, as you know but some others may not know, we are one tier trial system and right now my responsibility is I am Chief Administrative Judge for Juvenile Court for the State. I also sit as a Presiding Judge in Divorce Court and in the past I have been a Presiding Judge of major Criminal.

Juvenile Court in Connecticut deals with three types of cases: abuse and neglect that you have heard about today, delinquency, and status offenses which is runaways and truants, etc. Substance abuse is one common threads seen in all three types of cases along with other common threads of one parent families, teenage pregnancies, school drop-outs and poverty income. And if I had to add a fifth one it might be learning disabilities. You see those threads in all. The media is very familiar with the interrelationship of drugs and crime and violence, but there is a substantial relationship with substance abuse in neglect and abuse.

In the last 5 years, we have seen almost 100 percent increase in abuse and neglect cases in Juvenile Court in Connecticut. That is substantial.

Under our law in Connecticut, if somebody comes in—a social worker comes in and did this morning in fact before I left Connecticut, to take a child into custody because that child, well, he could have been physically injured, suffering from a physical injury or imminent physical danger, I will sign an ex parte order and in 10 days we would have to have a hearing. Those temporary custody hearings have increased 500 percent in 1 year. Now, about 80 to 85 percent of those are interrelated with substance abuse, cocaine, particularly addicted mothers or infants who are HIV positive. That is dramatic. That has an obviously very substantial implication to the court system. I have to move the business—my responsibility administratively is to move it, but aside from that we are dealing with human beings, children, and unless the children get into some sort of permanent status, somewhere in their lives in a relatively short period of time, we are losing those children. So, my responsibility as a Judge and other Juvenile Court Judges are essentially is to—after a child is brought into the system, is to set if you wish a road map by which that child presumably is going to go back to the natural parents, at least that is the way the State and Federal law is designed. And it has to be done within a reasonable significant time to have any impact on that child so the child is not lost.

This year, numbers make that much more difficult obviously. Our staff has not increased. As mentioned, most social work staffs have not increased. So, if we can't move a child—second of all, one of the things that I would do if a case was brought into me is I set expectations. That means there has to be a hearing with a short period of time. There has to be by Federal and State law a certain mandated review process of a child that has been committed to the State. I cut it even in half, but I don't think you can move—I would normally have a review in 3 months on a child that I commit because if something isn't done in the first 2 months to start either the mother in treatment or something to happen, it is going to drift. I know it and everybody else knows it, so my hammer is to have a hearing soon enough and essentially to say in some respects to the mother sometimes, "You better deal with this problem." My biggest problem, of course, is that if there is no treatment programs which are—they are sparse and few between, how do you say to a mother get drug treatment when it takes several months to even find a program.

So, we play a circular game and essentially what occurs is the children get lost in the process. This is not unique to Connecticut and it is not unique to New York, and it is not unique to California.

I was out in the Judicial College, I talk to judges all over, Juvenile Judges. This is a nationwide problem. You name the State and they have a problem. So, it is not a parochial interest and I am very glad therefore that you are involved in this process.

I think one has to address certain issues and address them early—I think there are two parts to this problem. One is dealing with the issue on a short term basis—what do we do with that which is there, but even more importantly, what are we going to do for the future? I think it could have been reasonably predicted. For example, our criminal justice explosion could have been reasonably predicted 4 to 5 years ago. I was handling an arraignment court 10 years ago in Hartford. The average number of cases that we brought in that year was 10,000. I had three judges and myself and we processed 10,000 cases, to see 9 years later it is now 20,000. I predict that unless something is addressed to this issue, in another 10, 12, 15 years, we are going to have a real serious problem. And I think one important statistic that has not been mentioned that predicts this is the number of teenage pregnancies. We can keep on closing our eyes and saying the problem is going to go away—it is not, and we are going to reap the harvest in about 12, 15 years because if you think this generation has problems, you just wait.

[The prepared statement of Hon. Judge Barall follows:]

PREPARED STATEMENT OF JUDGE HERBERT BARALL

Senator Dodd, members of the committee, I would first like to take this opportunity to thank Senator Dodd for affording me the opportunity to address this gathering today. I am Judge Herbert Barall, Chief Administrative Judge for Juvenile Court for the State of Connecticut; in addition I am Presiding Judge of the Family Court in Hartford and am presently sitting on the bench in delinquency and divorce matters.

I have been asked to address the subject of substance abuse and its affect on the neglect and abuse side of the Juvenile Court in Connecticut.

The Juvenile Court in Connecticut deals with three types of cases: Neglect and abuse cases, delinquency cases, and status offense cases. Substance abuse is one common thread seen in all three types of cases along with the common threads of one parent families, teen-age pregnancies, school drop-outs and poverty income. The media has vividly described the interrelationship between drugs and crime and violence, but there is, also, a substantial relationship between substance abuse and neglect and abuse.

In the past five years, the Connecticut Juvenile Court System has seen a dramatic rise in neglect and abuse cases. In the last five years there has been almost a one hundred per cent (100%) increase in filings related to abuse and neglect.

More particularly, in the 1983-1984 court year, 1954 petitions were neglect, termination of parental rights, revocations and extensions of commitments. Five years later, in the 1989 court year that number has increased to 3,580. Although precise statistical data is not available for these five years, those who work the trenches can attest to the significance of substance abuse as a causational factor in the increase in the number of cases during that period of time. During the first nine months of 1989, compared to the same period in 1988 there has been a twenty-two percent (22%) increase in cases in which parental substance abuse was the main causational factor in the child being neglected or abused. Substance abuse has not only implicated a general increase in the number of cases but also has caused an increase in the number of cases that are presented to the court on an emergency basis.

Under Connecticut State Law an order of temporary custody of a "child may be awarded ex parte to the Department of Children and Youth (DCYS) if affidavits submitted to the Judge persuade the judge that the child has been seriously physically injured or is suffering for a serious physical injury or is in imminent physical danger from surroundings and immediate removal from such surroundings is necessary to insure the safety of the child. In those cases, the court must hold a hearing within ten days of that ex parte order and the petitioning party usually DCYS must prove its allegations previously presented on affidavit form. This process essentially telescopes a cases progress as hearings must be held within the statutorily mandated time of 10 days. Ex parte orders since last year have been magnified 500%. Eighty to 85 per cent of those cases requiring ex parte orders can be attributed to parental substance abuse, especially infants born of cocaine addicted mothers or infants born HIV positive.

How does substance abuse impact the Juvenile Court in Connecticut? Obviously, it makes us a very busy place. While the number of cases and the complexity of cases have risen, the staffing level of Judges and support personnel have not. If we were producing "widgets," we could afford to say that the greater influx will merely delay production. Unfortunately, we are talking about the lives of children who have been neglected and abused. Parental substance abuse results in children being abandoned, homeless, denied basic necessities of food, clothing, medical treatment as well as safe crime free environments. The increase in caseload plus the complexities of the caseload means delay and delay means larger disruption in the lives of children who have already been traumatized. Those delays cannot be made up casually by the children we deal with.

Federal law and state law as well as court policy provide for a process of continual review of both old and new cases.

In these reviews judges and support staff must monitor files with the intent of assuring that all reasonable efforts are being made to prevent removal from birth parents and in the cases where children-are removed and placed in foster care that reunification is facilitated and when this is not possible that a permanent plan is adopted for the child.

In Connecticut, Judges set court expectations to lay out a clear road map for parents to remediate the problems which required court intervention and in a majority of cases required removal of children from their homes and placement in foster care and also to provide a benchmark for the court in its later judicial review of cases.

These expectations outline specific services and guidelines which parents must follow to help themselves and to address the issues which caused judicial intervention.

In cases where judicial finding has been made and disposition entered, expectations are formalized quite often based on clinical input and with the agreement of all parties involved i.e. DCYS, parents and counsel for all parties. In substance abuse cases expectations are most often spelled out to reflect parent(s) need for treatment and intervention. In Connecticut, as in other states, treatment resources, especially, inpatient are virtually non existent and the programs that do exist are so overcrowded that individuals sometimes wait 3 to 4 months for treatment.

Most of the individuals the court is involved with have no financial resources, therefore, they must rely on welfare assistance for treatment, medical services, housing, etc., further limiting their ability to obtain adequate services and resolve the issues as the court directs. What this means for the court is delays in implementing reunification and realistically reducing the chance that reunification will occur. This increases the likelihood that the court will continue to remain involved in any given case much longer than we should be.

The court recognizes the need to be sure that children do not languish in foster care. In Connecticut, we see the lack of foster homes for children, especially children born of cocaine and/or crack addicted mothers who have a multitude of problems from birth or who are HIV positive. We cannot afford to play a numbers game with children. They suffer and eventually society as a whole suffers.

What we need is resources and resources require money and commitment on the federal, state and local level to take a serious look at the situation as it exists today and to empower courts and child welfare systems to assist parents but more importantly to safeguard children.

In closing, I would like to relay to you a scenario of a case which was pending in our Juvenile Court. An infant, Ashley and her two older siblings were placed in the care of DCYS voluntarily by their mother as she was evicted from her apartment for violating the rules of the public housing complex against drug dealing. The children were placed in foster care and a petition seeking an adjudication of neglect and uncared for and commitment of the children was filed in the Juvenile Court.

Shortly after being placed in foster care, Ashley's foster mother became alarmed because the child was having mild seizures. Ashley's doctors were hard pressed to find a cause but treated her with anti seizure medication. One day Ashley had a serious seizure and despite every effort she died at 6 months of age.

After a long, protracted investigation by child welfare workers and the police they were able to determine that Ashley's mother stored the cocaine she was using and selling in baby bottles which have ounce measurements. Over time, Ashley ingested a sufficient amount of cocaine residue to cause her to have either neurological or brain damage resulting in the seizures. Ashley's mother was too coked out to even attend Ashley's funeral.

Why am I relaying this story to you? Because parental substance abuse is real, while it may affect the court it truly affects the children of our state.

Again, thank you for including me in this proceeding and I applaud and support your continued efforts in the area of substance abuse prevention and intervention.

Senator DODD. Thank you, Judge. Dr. Finnegan, we appreciate your presence.

Dr. FINNEGAN. I am pleased to have the opportunity to address the Senate Subcommittee on Children, Family, Drugs and Alcoholism at its hearing on "Children of Substance Abusers." I presently hold the position of Professor of Pediatrics and Professor of Psychiatry and Human Behavior at Jefferson Medical College of Thomas Jefferson University in Philadelphia. In addition, I am Executive Director of Family Center which is a program designed to provide intensive medical and psychosocial services to drug and alcohol dependent women, in general, and to provide specialized care to those who are pregnant. I am also pleased to announce that I have joined the Office for Treatment Improvement of the Alcohol Drug Abuse Mental Health Administration in the Department of Health and Human Services as its Associate Director. I am looking forward to my new position. Today, however, I am testifying as a neonatologist, that is a physician who is trained in the newborn baby, and as a drug abuse clinician and only as to my personal views. I am not today representing the Office for Treatment Improvement.

Comprehensive medical services at Family Center include a prenatal clinic at Thomas Jefferson University Hospital which is staffed by obstetricians specifically trained in the field of addiction and high risk pregnancy. Additional treatment modalities include individual, group and family therapy. Methadone maintenance and in-patient detoxification are available. AIDS prevention counseling and testing are provided and educational services in the form of prenatal and parenting classes are also offered. Infants who exhibit withdrawal symptoms are treated in the newborn nursery by our neonatal physicians. Services of Family Center are aimed at eliminating drug use, developing personal resources, improving family and interpersonal relationships, reducing and eliminating socially destructive behavior, and facilitating maximum attainable adaptation for new parents within their environment.

Over the last I guess 20 years that I have been working in this area, within the service and research goals of the program, we have found that we can rehabilitate a significant number of women who have enrolled during pregnancy and therefore reduce maternal and infant morbidity and mortality. When material medical and obstetrical complications are treated, a similar outcome is seen in the drug dependent mother as in the general population of the same socio-economic and ethnic classes. Moreover, we have been able to reduce the incidence of low birth-weight infants from nearly 50 percent as seen in the heroin dependent mother who has no prenatal care, to 18 percent in those mothers who are maintained on Methadone and are provided with our comprehensive services. This reduction is significant in terms of neonatal morbidity, mortality and medical costs. Presently, a two pound infant will accrue medical expenses totalling approximately $150,000 in the first 3 months of life, and hundreds of thousands of dollars more in rehabilitative costs and foster care.

Our research with regard to the infant has resulted in treatment protocols for infants undergoing abstinence. Within our long-term follow-up studies, we have found that the provisions of these perinatal services to this very high risk population results in infants and children who are developmentally, neurologically and physically normal.

Family Center also recognizes that addiction is more than a medical issue. The women are weakened by unemployment, illiteracy, homelessness and legal issues. Our research demonstrates that many environmental variables contribute to addictive behaviors. For instance, one Family Center study compared drug addicted and nonaddicted women from similar socioeconomic backgrounds. There were significant differences in the following areas. Nearly 70 percent of the drug dependent women experienced early sexual abuse before the age of 16. In the nonaddicted women, 15 percent had been abused sexually, remembering that these women are all coming from the same neighborhoods in the City of Philadelphia. Eighty-three percent of the drug dependent women had a chemically dependent parent. Seventy-five percent of those parents were alcoholic and I might add that alcohol is a drug, nicotine is a drug, just as cocaine and heroin, so they are all drugs, it is just that two of them are legal and the other ones are illegal so somehow we think that they are better, but in fact, they are quite worse. We have 1,000 people that die daily because of the results of nicotine and its effects on health.

Senator DODD. Doctor, I am glad to hear you say that but you deal with that legislation. I didn't find out about that until we passed it. When I tried to do something in the area of alcohol abuse, they told me I couldn't do it because that legislation with $10 billion in it last year, is drug abuse legislation and that alcohol didn't play. I wish you had been there. You say it with such certainty.

Dr. FINNEGAN. Invite me next time, because when you talk about the effects on babies, I can assure you that it is very devastating.

In contrast to the drug dependent women, 35 percent of the non-addicted women had a chemically addicted parent. The families of the drug dependent women had higher levels of family conflict, physical violence, and lower levels of family cohesion. Treatment therefor must respond to each and every one of the medical and social variables which complicate addiction and recovery. For instance, while Methadone may encourage a heroin free existence, reduce the excessive exposure to human immunodeficiency virus and assist in the provision of healthier infants, it does not answer the social problems faced by the Family Center women. Problems associated with support issues, food access, housing and day care and overwhelming to the recovering female addict. Relapse is imminent when daily survival is at risk. Our cocaine dependent, pregnant mothers present us with corresponding complex social ills, as well as the same kinds of medical problems that we seen in the heroin dependent women which include abruption of the placenta, stillbirths, decreased infant birth weight, length and head circumferences.

Drug addiction is a most debilitating disease due to its chronicity and intermittent relapses. Moreover, and specifically with regard to children, it has long range and intergenerational implications. It is even more devastating to the drug dependent women and mothers who so frequently do not have the resources for recovery available to them. The words of one of our parents, a 35 year old white woman with three children who was physically and sexually abused as a child and who subsequent to her mother's death, at age 15, began to use psychoactive drugs are most relevant. She says, "Drug addicts are human beings who have the same hopes and dreams that you do. I love my children, bit it is not easy to stop taking drugs. Treatment has helped me to recognize how my background has influenced my addiction. I medicated my pain for a very long time. Now I can talk about this pain and face it without running away through the euphoria of drugs."

Because of the lack of treatment services and research endeavors within the drug addicted population for so many years, we are now plagued with rampant drug addiction in our country. Because of the intergenerational transmission of the disease of addiction, as a country, we have fostered a spiralling legacy of addicts giving birth to addicts. This dark reality of gloom has now developed into the fact that soon we will have many thousands of babies at our door-step who are dying from AIDS. If but only 10 percent of the resources for treatment and research provided for such conditions as cancer, heart disease and stroke had been applied to this population several decades ago, we would not have the overwhelming problem of rampant addiction. As a result, we have the concomitant tragedy of babies that are handicapped not only because of their premature birth, potential for congenital malformations, the develop of AIDS, but also their debilitating psychosocial environment. We have had a drug abuse epidemic for a quarter of a century and due to the lack of resources for treatment, research and education, as well as the lack of interest by professionals, we haven't done anything effective to reduce this devastation upon our women and our children. We have now reached uncontrollable heights in this epidemic of drug addiction. This generation of children is suffering greatly due to our previous unwillingness to act with urgency to turn the tide against this tragedy that has befallen them. We must remove the barriers to effective prevention, intervention and treatment of drug dependent mothers and their children.

With two decades of experience in the treatment and research issues with this very high risk population of mothers and infants, I recommend the following. First and utmost, I believe that there is an urgent need to expand the availability of Methadone to pregnant and postpartum women who are intravenous heroin abusers, but it must be coupled with comprehensive treatment services. Appropriate surveillance with programs treating these women is essential in order to monitor them and to give them appropriate public health advice with regard to the human immunodeficiency virus. Caring professionals who are also knowledgeable in the field of substance abuse must put the treatment of women in the context of their reality.

Second, due to the complications associated with addiction, our energies with regard to treatment and prevention must have as its priority, housing and education. The Family Center is striving to obtain the resources for a building and the staff to provide residential treatment for 50 cocaine addicted women and their children. We have designed a residential program which would provide intensive drug and medical treatment, as well as an extensive educational and job training component. This would allow us to address the significant issues of housing, education, job training and family dysfunction in drug dependent pregnant women. In addition, we will be able to influence the development and socialization of their children. This kind of a project could serve to eliminate the medical and social problems experienced by the drug dependent woman and her children, particularly those that are cocaine dependent and for whom there is no pharmacotherapeutic agent such as methadone. Appropriate services for the follow-up of these pregnant women is also essential. And, finally, the issue of abandonment of the children and foster care needs must be addressed and planned appropriately, and you have certainly heard a lot about that today, you can see the need. It is the very least that we must do so that we can be assured that future children born in this wonderful country will not be plagued by the pain and suffering of drug addiction. By following the above recommendations, we may have hope for these children by avoiding the destruction of the very fiber of our country—The Family. Thank you.

Senator **Dodd**. Thank you very much Doctor. I think I said it at the outset, but I may have mentioned it to the Mayor and I think the notion of trying to get 50 beds, I mean, it doesn't even address a fraction of the problem yet, the success rates in treatment apparently are very high.

Dr. **Finnegan**. It is a start.

Senator **Dodd**. I agree.

Dr. **Finnegan**. I just spent the last 2 years of my life just trying to get this and at this time as we speak my staff and the officials of Jefferson are meeting with the Archdiocese of Philadelphia hoping that they will give us a convent, that used to house 40 nuns, which has been empty, sitting there, rotting away for 2 years and I am sure that within every State in this country, there are many, many convents and many Federal buildings that are sitting there and being unused that could be renovated and used for these mothers and children, and that is where we need some help from all of you in order to be able to get through some of the red tape and, believe me, it is red tape. It is enough to give you palpitations and hypertension.

Senator **Dodd**. Well, let us know about just that one particularly. I can certainly speak with Senator Heinz and Senator Spector who I think would be very interested in being of help on that in Pennsylvania. Clearly, Bill Gray, certainly, is a very good friend. I am sure he would be delighted to help you out. And also we have the Younger Americans Act, which copies the Older Americans Act, where you have the coordinated services for the elderly in this country, in a very effective way. We have just failed to do it for children and that is part of why we are behind in this today.

Dr. **Finnegan**. But, you see there is a long research out there and we still need a lot more research but the point is that the research to date, in our programs and in many programs throughout the country have clearly shown that we can do well by the mothers and the children, if we can implement these treatment centers. In my particular situation, on many, many months, the hospital has bailed me out because I couldn't pay my rent, so these are the kinds of things that need to be boosted and I think that with the current efforts that we may be able to do will put a little dent in it this year, but we are going to have to keep doing it because, as I said, it has been there for a quarter of a century and we just haven't done anything.

Senator **Dodd**. Part of the difficulty of calling these things wars is that we have this notion in our mind that wars end, and this is not a war that ends. Substance abuse has been around as long as humanity has and it is going to be with us for as long as we are here. It is a constant on-going battle that you can never give up on. We must get that notion through. When we call something a war, we create the illusion, I think, in our constituents minds that if you just stick with me for a year or two or three or five, we will "win this". Now, granted, you can get some reductions in the numbers, but the fact is you have got to do it forever. You have just got to stick with it. There are people right now as we are sitting here today thinking up and manufacturing substances that you don't have to grow in Colombia or Mexico and bring here, substances that are going to be cheaper than crack and more available to people than crack, and they are sitting there trying to figure it out. So, while we are trying to figure out a way to deal with the present problem, there are people who are already ahead of the curve and manufacturing something that might even be qualified as legal, so that is a change of definitions to deal with.

Dr. FINNEGAN. They are already here Senator.

Senator DODD. Mr. Marion, we thank you.

Mr. MARION. I thank you for inviting me here and allowing me to express my views and just to add a comment to your raw story, I don't know that we ever fight wars with budgets, certainly not with limited budgets where you need to issue a purchase order to get more bullets, you know, and I think—I am going to try to say why, why now, and what if I can, and I think until 5 years ago, at least in New York, the issue of children of substance abusers wasn't even put on a table as an issue and programs like that of Dr. Finnegan's in Philadelphia were unique in this country in doing this kind of work.

Unfortunately, the statistics that exist now as a result of the 5 years of efforts on behalf of the children of substance abusers in New York State are pretty devastating. We do have some numbers which I would like to give to you and give to the audience. There are 467,000 children in New York State who are the children of substance abusers. Of those, only 59,000 of those kids have parents who are in some form of treatment. The rest have parents who are essentially untreated and continue to use and abuse substances. There has been a tremendous increase in babies born with positive toxicology. In 1983, 884; in 1986, 2,586, and that number continues to double every 2 years.

In my own program, we treat 3,250 patients, but these statistics are based on 2,800 patients; 875 of whom are women. In 1989, approximately 18 percent of them were pregnant, which is an alarming number of pregnancies, just in any group population. Of those 167 pregnancies, 74 live births, 24 of those births were HIV positive, 47 resulted in termination of pregnancy largely because the woman found out that she had a 50/50 chance of transmitting AIDS to the fetus; 4 miscarriages and 42 are still pregnant, from that data.

Another important statistic I think at least from the treatment perspective where I come in is that as little as 10 years ago, there were four men to every woman in drug abuse treatment programs and halfway through the last decade, that changed to 75 percent/25 percent. At this point, it is 65 percent/35 percent. The number of women coming into treatment is increasing tremendously and the proportion of men to women is changing radically and we are talking about a treatment system that, as Dr. Finnigan pointed out, predominantly run by men, for men, without recognizing the needs of women patients and until we reorient and redirect the way we do treatment, I think that we are going to be in big trouble.

Why should we do it now? We heard a lot about foster care today so far. Boarder babies, the problems that foster care issues present, but only 15 percent of the children of the patients in my program are in foster care. Of 4,400 children that we have identified as being born to our patients, 3,000 of them are under the age of 18 and in the custody of their parents. Twenty percent of those kids or 600 have an active Child Protective Services case and only 15 percent were in any form of surrogate care, and that is including foster care, it could be a parent, a grandparent or somebody else.

What should we do? First of all, let me tell you that Albert Einstein College of Medicine runs a division of substance abuse. It is a large multiclinic program with children of substance abusers and family service programing as well as Methadone maintenance treatment, research and teaching and it is the largest medical school run program in the country. Most medical schools are not in the business of providing substance abuse treatment at all—research certainly.

We have been able with the help of our State agency and others to redirect the existing services in our program and this is a recommendation that I would make that does not require money. Substance abuse is a family illness and for the most part the existing treatment that is done in these programs is done for individuals and if we redirected the way case work and counseling and group services were done to families instead of to individuals, I think we can achieve a lot with what we already have. We do parenting groups, parenting training. We provide direct services for children, medical, social services, educational intervention. We have a pregnancy outcome enhancement project which has been tremendously successful. This is out-patient not residential where pregnant women are—we have had 80 percent increases in prenatal care and 50 percent decreases in prenatal substance abuse by providing intensive case management and coordinated services for women. HIV services, including early pregnancy detection are critical components, as is drug education and day care.

The program that you visited, Odyssey House, this morning is very rare in its ability to take women and their children into treatment. In most cases, we are asking the woman to go into residential treatment, to give up her child and whether to accept treatment. So what she is confronting is on the one hand, I want to get better, I don't want to snort cocaine and I don't want to be sick anymore, but I have to give up a part of me in order to go there, and I venture to say that is asking an awful lot of people and even if Loretta's 50 beds come into play and we get another five Odyssey Houses as I learned 5 minutes ago in New York, we are still going to be asking people an awful lot. There has got to be a way where these kids do not have to be given up into foster care. They can either go with them into residential treatment, or be treated in an ambulatory facility, a day program or some other services, to get help.

One of the big problems that exists and we have heard some of it this morning, is there is little if any cross training. When you are dealing with children of substance abusers, you are dealing with multiple agency contacts—there is a drug treatment agency, a child protective services agency, a Welfare department, a foster care agency, etc, and very little—all of those disciplines are unique unto themselves and there is very little cross fertilization and cross training. With that, we would start to learn about each other lingoes and each others needs, and presumably result in better interagency coordination, better referrals and better case management skills.

The emphasis on foster care, I believe, is while I think it is absolutely necessary and kids cannot be left in dysfunctional homes, I think if we define substance abuse as child abuse and neglect and remove children from a home because there is some substance abuse in that home, we are in for a devastating issue in this country that will never—I mean, the cost of which would be so staggering we would never recover from it. We have to work for family preservation. We have to find ways that like the Odyssey program, that teaches people to be good parents and to keep that family in tact, to encourage patients to bring their children into treatment programs.

One problem with children of substance abusers is that they are not seen, they are not known to any system until they are five or 6 years old. Once they are born, they are hidden, there is very little day care, they are not encouraged to go outside, and so the systems don't get to know these patients.

We have got to find ways of having a continuum of care. I am certainly an advocate and in our program we do this early and the routine pregnancy testing of all women in substance abuse treatment programs—a very inexpensive way of catching pregnancy as early as possible. Many women who use drugs do not have regular menstrual cycles, do not find out they are pregnant until they are three, 4 months into the pregnancy, and their options become much more limited as that pregnancy proceeds. It is possible to do in drug treatment programs where they collect urine specimens routinely anyway, to do routine urine screening for pregnancy and discover that pregnancy as early as possible so the options are as great as possible for the women.

We live in a generation of 35 year old grandmothers. A lot of people are talking here about have we lost a generation. We have got kids who have kids who have kids and many of whom are still in very early stages of their own rehabilitation and if we don't act fast and with our existing models, whether it is health care or drug treatment, put in a family component that involves preservation of the family as the major goal—as a major goal, and I think with that you will see substance abuse declines as a benefit of the family stability rather than as the focus itself.

I don't know if you remember Senator but about two and one-half years ago, you were a speaker in Stamford at a Methadone treatment conference and two kids got up and spoke about what it was like to watch their parents as heroin addicts and then to see their parents as Methadone patients, and the change that came over their parents that (a) when the kids parents were addicted—first of all, let me say those kids came from my program and that is why I am bringing it up, I am very proud of that, but the bottom line for the kids is they weren't kids when their parents were addicted because, like Rodney said before, he had to cook the meals, he had to worry about his mom waking up tomorrow morning or what have you. So the kids are denied the benefit of their childhood. When parents got into treatment and could function as parents, the kids (a) became kids again and had a chance to have a youth and the parents assumed the responsibility for proper parenting of those kids and avoiding all of these systems like foster care and what have you, and I think that may be—to conclude my remarks, the best hope for us is if we can use the treatment experience to keep families together.

[The prepared statement of Ira Marion follows:]

Prepared Statement of Ira J. Marion

Senator Dodd, Members of the Senate Subcommittee on Children, Family, Drugs and Alcoholism, I want to thank you for asking me to present my views on the important problem of Children of Substance Abusers (COSAs).

When New York State convened a Task Force on COSA three years ago, nothing was known about the special strengths, weaknesses, needs or problems of these children—and no services were in place to specifically help or encourage them. The New York State Division of Substance Abuse Services (DSAS), New York State's single state agency, has since developed innovative and pioneering programming for these children and their families.

New York State has recognized the importance of current and future generations of children who endure epidemic substance abuse, homelessness, HIV infection or AIDS and poverty. As the Director of the second largest substance abuse treatment program in New York state, which operates one of the three original State funded COSA pilot programs, I have documented the suffering of babies born to addicted men and women and the disruption that substance abuse causes the entire family. As an administrator, I have seen the bureaucratic disaster, created by regulations, funding protocols and priorities, politics and hierarchical service delivery systems that impede our ability to quickly address the effect of addiction on children and families. These obstacles make it almost impossible for us to develop rational programming to reduce the risk to children who grow up in homes and communities where substance abuse is endemic.

STATISTICAL INFORMATION

The numbers speak for themselves. The New York State Division of Substance Abuse Services (DSAS) estimates that there are 467,000 COSAs under 17 years of age in New York State alone. Of those children, only 59,000 have parents who are in some type of substance abuse treatment; almost half under six years of age and in the custody of adult substance abusers not now in treatment. According to the New York City Department of Health, there were 884 children born to substance abusing women in New York City during 1983. In 1986, that number rose to almost 2,600 (2,586).

During the last two years, the number of infants born to drug addicted women in New York City has doubled. The number of infants who must remain in hospitals, babies we now call "border babies" continues to grow in direct relation to the increase in parental drug use and drug-related problems, particularly crack/cocaine and AIDS. When we speak of the crucial need for "treatment on demand," we are speaking not only for the generation of adults and youth already addicted and helpless, but more emphatically for the benefits their children will derive. These children will almost certainly follow in their parents' footsteps if effective programming is not developed quickly.

It is well documented that the majority of untreated addicted parents have children who are at risk for a number of serious problems, including, medical, academic and emotional problems, and, of course, substance abuse. These problems, combined with poverty and HIV infection or AIDS, has created a generation of children in crisis. In many ways this is at the center of our crisis in education as well, for many of these children manifest learning disabilities.

We state it time and time again—children are our greatest natural resource. They represent our hope for the future. Yet, our work tells us that the majority of COSAs are under the age of 12 and are living with parents who are currently addicted or heavily abusing drugs like crack/cocaine and heroin. In an effort to impact on these problems and on the intergenerational cycle of addiction, the Albert Einstein College of Medicine (AECOM) Division of Substance Abuse (DoSA) instituted our State funded demonstration project, the COSA Project, to learn about the children of substance abusers and to develop programming for patients as parents and for their children at risk.

As we work directly with parents and children, we have had opportunity to note the relationship between deficits in parenting skills (including inconsistency, abuse and neglect) and marked problems in the children of these active addicts soon to become patients. In essence, the problems of our patients were dramatically reflected in their children.

BACKGROUND INFORMATION

The Division of Substance Abuse of the Albert Einstein College of Medicine, in addition to research and teaching, operates the largest substance abuse treatment program under medical school auspices in the nation and the second largest treatment and prevention program in the State of New York. It is important to stress here that addiction treatment is prevention, in that addiction, like other diseases, is spread from person to person. By successfully treating an individual, we interdict the spread to others horizontally and vertically, including those innocent children about whom we speak.

At Einstein, we currently treat over 2,800 patients who live or work in Bronx County, an area significantly impacted by drugs, poverty and insufficient availability of treatment and other resources. Most of our patients endure the stresses of living with poverty, unemployment, inadequate housing or homelessness, frequent changes of residence, chaotic home lives, broken families, inferior schools and discrimination. To address the primary substance abuse, we offer methadone maintenance treatment to opioid addicts, including AIDS education.

We provide programming and linkages with the criminal justice system through our Key Extended Entry Project (KEEP). The services of our program include among others, educational and vocational counseling, medical and social services. Our most recent Annual Report and other Division of Substance Abuse publications are appended to this testimony for a more comprehensive understanding of the AECOM DoSA and its programs.

THE CHILDREN OF SUBSTANCE ABUSERS PROJECT

In our treatment clinics, approximately 75 percent of our patients are parents. About 4,400 children have been born to our patients; and of those children, 3,000 were in the patients custody and under the age of eighteen. A preliminary needs assessment revealed that the children of patients who were new to treatment or were having difficulty progressing in treatment, were exhibiting multiple problems including behavioral disorders and medical and academic problems.

The largest age group of children experiencing medical problems or adjustment difficulties were those under the age of five. Those were children who were not identified through the mainstream health and social service system and were under age for identification in the educational system. Simple services such as routine health care, day care and child welfare preventive services were not accessed. These children were least available to services at the most critical ages. The scope of the problem of pregnancy among addicted women in general, is tremendous. Among our patients, we were aware of 110 pregnancies in calendar year 1987. Of those, 51 babies were born; the other pregnancies were terminated, either voluntarily or through miscarriage. However, of the 51 babies, 4 are deceased and 47 percent, or 24 children, are HIV positive.

The AECOM DoSA integrated identification, evaluation and referral services for children of patients into the regular services of the program. Services for "patients as parents" include parent education and support groups, advocacy regarding child protective services and school-based services. The original project grew to include services for pregnant women and their families. Most of the patients were eager for assistance in caring for their children. It became evident that this drug treatment program provided a point of entry to medical and social service systems for the children of patients who are traditionally disenfranchised and alienated from such services.

In our Pregnancy Outcome Improvement Project, funded by the New York State Department of Social Services, we are able to follow pregnant women from the identification of pregnancy until three months after the child is born.

At the inception of the project, we had 32 pregnant women; 27 percent were enrolled in prenatal care and 65 percent were abusing alcohol and cocaine while enrolled in methadone treatment. After only four months of the intensive treatment provided by the project, 87 percent were enrolled in prenatal care and, only 25 percent were abusing drugs or alcohol as determined by urinalysis. In addressing pregnancy outcome, the COSA project is fortunate to have the back up facilities of the AECOM which provides HIV/AIDS services, Obstetrics and Gynecology services, pre, peri and neonatal care, general medical services and mental health and social services. These facilities are not, as a rule, as readily available to many substance abuse treatment providers.

Presently and specifically, children and family services in the Division of Substance Abuse today includes:

—Identification and evaluation of patients children who are experiencing behavioral, learning or health problems.
—Therapeutic interventions with parents and children, both in individual and group situations.
—Parenting education, parent training and parent support groups in each AECOM clinic.
—Prenatal medical and psychosocial services identifying and working intensively with pregnant patients and the parents of newborn children, assuring attention to prenatal care and HIV/AIDS related issues; facilitating the patients transition into their roles as parents.
—Staff training and sensitization to the special needs of children of substance abusers and to patients in their role as parents.
—Referral and advocacy for patients and their children with community based resources including child development and family and mental health centers, child advocacy and legal services, educational and vocational programs, recreational and after school centers, day care providers and parent programs.
—Ongoing liaison and coordination of services with community school districts and school based substance abuse prevention and intervention programs servicing patient's children; targeting children with identified learning, emotional and school related problems and accessing special services for children within their schools or districts.
—Preserving the integrity of patients' families, preventing foster care placement and assisting in reuniting families whose children have been placed.
—Training of community based service agency staff in substance abuse issues and in the unique needs of methadone maintenance treatment patients and their families.
—Resource development for service professionals.
—Provision of clothing, summer camp scholarships and holiday toys for children so that more intensive treatment for their parents can continue while the children enjoy a therapeutic experience.

The development of these services, although dramatic for us as a treatment program, was not unwelcome. Many patients began to access these services once they were available. Attention to the problems of parents and to the problems of their children made treatment more attractive and relevant to addicts. In fact, many prospective patients selected the AECOM DoSA because we offer services for children and families. When services are tailored to meet patient needs, addicts seek them out. Although there may be other reasons for this, over the last five years the ration of male to female patients has changed from 80:20 to 65:35.

In addition to funding from the State of New York Division of Substance Abuse Services and Department of Social Services, we receive support from the National Institute on Drug Abuse as well as some private foundations.

RECOMMENDATIONS

Senator Dodd, you will recall that in 1987 you spoke at the Third Annual Northeast Regional Methadone Conference in Stamford, Connecticut. You were proceeded by two teenage children who told of their personal experiences as children of substance abusers. They told what it was like when their parents were addicted and the difference that the treatment program made in their lives. In this case, these were children of patients on our program. It is their stories and hundreds more like them that speak to the effectiveness of substance abuse treatment for the entire family constellation, not just the individual being treated.

These children, old and wise before their time, lost their youth caring for parents who did not care for themselves, lost in the universe of heroin addiction. These children were the parents. They cared for younger siblings and made sure there was food on the table and clean clothes to wear. When effective treatment was provided to their parents, the kids not only regained their opportunity to be children, but also acquired parents. Too often, this potential is lost because most substance abuse programs are not family oriented and do not provide integration of services.

Services for the children of drug addicted parents assist in the total rehabilitation of the addict. Treatment services must regard the addict in the context of the family. Comprehensive care of families is critical to the health and well being of COSAs. Identification and early intervention in the problems of COSAs will prevent educational, health, and substance abuse problems in the future. For example, the psychological harm of family disruption and the costs of foster care placements can be offset by provision of medical and social service supports which improve the health outcomes of the newborn and facilitate mother child bonding.

While the problems of children of substance abusers are experienced in a variety of systems including the educational, medical and child welfare systems, the nature and function of those systems encumber service delivery. Staff in other service areas are generally not trained to work with drug addicted parents. Our patients are approached with apprehension and prejudices rather than with understanding or empathy. The parent may not respond to services and may be considered difficult to engage. Misinformation has caused unnecessary disruption in the family lives of some of our patients. For example, one patient who has been very successful in treatment recently gave birth. As a result of the presence of methadone in the infant's urine, rather than contacting the treatment program, the hospital social worker notified child protective services. Unaware of methadone treatment, the child protective worker informed the new mother that she would not gain custody of her baby until she was not in treatment. The infant was unduly retained in the hospital, and the mother and child were needlessly separated. It is imperative that training agencies which deal with drug addicted parents and/or their children be trained to better understand addiction and addictive behaviors in order that they might appropriately and effectively intervene in these families.

Additionally, as the problems of COSA confront a variety of local, state and federal agencies, the structure and bureaucracies of those agencies hamper provision of coordinated services. While different agencies, by structure and function, are accustomed to working in their respective fields, by nature of the needs of these children, it is crucial that services for them and their families be coordinated. Rather than providing a continuum of care, the various systems sometimes duplicate services and sometimes work in isolation. As in the aforementioned example, in which both the medical and child welfare systems failed to refer to the drug treatment services. Linkages among systems must be developed to facilitate service provision for these families.

Finally, it must be noted that funding bureaucracies create their own barriers to developing the linkages which would provide a continuum of care. For example, AECOM was chosen as a demonstration site for a cooperative pilot project between the New York State DSAS and the Office of Mental Retardation and Developmental Disabilities. This project was to link the services of AECOM's Rose F. Kennedy Center for Developmental Disabilities (OMRDD) and AECOM's Division of Substance Abuse. This project was devised because OMRDD has seen a tremendous increase in developmentally delayed children whose parents are substance abusers and, presumably, HIV positive. The project was drafted and approved. It now awaits a "letter of agreement" between the two State agencies, which must be negotiated by the attorneys for each agency and then approved by the State Attorney General. Once this is accomplished, a contract will be drafted and sent to AECOM, which once approved by AECOM's attorney, must be signed, notarized, corporately sealed and once again, approved by the State agencies, the State Office of the Budget and the State Attorney General. Only at this point can the project move forward. In the meanwhile those in need continue being "ping ponged from one service delivery system—to another. This demonstration project involves no more than $75,000.

It must be stated that the current cost of services to COSA is extremely high as service delivery systems are duplicative and more expensive ineffective services are accessed in place of cost effective comprehensive family and preventive care. For example, many addicts use municipal hospital emergency rooms for routine acute care for their families. And, while there is no immediate outcome for providing vaccinations or social work services to teach parenting skills, the rewards are in not becoming sick, dysfunctional or addicted later in life. The rewards of doing moderately well in school or better social and educational adjustment, are not those that public policymakers can immediately see or brag about during their reelection campaigns.

We need to take the high road and realize that if we do not respond, an entire generation of children will be lost to crack/cocaine, heroin, mental illness and other problems of being raised in a home where the illness of "substance abuse" took precedence to food, clothing and shelter, school and health, even if we cannot count the successes in definitive terms.

Substance abuse is truly a family illness. The costs of drug use as it impacts on children is staggering. In order to keep families intact, to ameliorate the problems incurred by COSAs and to rescue our next generation from drugs, it is crucial that the needs of drug addicted parents and their children be addressed in a well coordinated manner. At the Albert Einstein College of Medicine, we have found that substance abuse treatment and prevention programs are extremely effective sites to address parenting skills, family needs and primary and preventive health care, and they are critical in identifying preschool aged COSA. Because of the number of complex problems faced by these children and the number of systems and agencies involved with them, coordinated human services and integrated funding must be considered.

I hope my testimony provides some perspective on the different issues and concerns of the Children of Substance Abusers, and I hope that today's effort will help focus on rescuing a generation of children who otherwise face their own inevitable entry into some treatment system. By redirecting our efforts to demand reduction, self esteem and hope for parents and children, we can make dramatic inroads in this area.

Senator DODD. I say Amen to that. I couldn't agree with you more as a goal. I have held you all so long here, I apologize for the length of all of this. I have a question I would ask both you, Mr. Besharov, and Judge Barall, given the fact that you are both very much in the forefront of the legal issues. There are two questions, really. One was raised at lunch today, Judge, before you got there, which is the parental rights issue. At what point do you say—if you don't have enough of Dr. Finnegan's programs or the Odyssey Houses around, if you can't get people into treatment, and you see this deterioration, you see the impacts on children—at what point do you say parental rights should be terminated? I agree with you, Mr. Marion, that we ought to focus on trying to keep those families together, but the issue arises. There was a thing on the other night on prime time television about such a case. I recounted back twenty some odd years ago when I wrote a law review article on a baby Lenore out of New York. It was a case—the same statutes, the best interest of the child and the two highest courts in two States reached absolutely different opinions on whether the adopted parents or natural parents should have had custody there. So, I would like to hear you both talk briefly if you could about that thorny question. While we are trying to get these residential programs going and so forth, at what point do you say the best interest of the child is such that it no longer should remain with that natural parent. No. 2, we have 50 cases pending now in the country where mothers are being either indicted or charged with child abuse because they were alcohol abusers or drug abusers. Those cases are going to raise a whole spectrum of questions about whether we discourage people from entering Odyssey House programs or Dr. Finnegan's program, if coming forward means you run the risk of criminal indictment. But, again, in the absence of doing anything, do you just neglect that kind of problem and let it go by the boards when, in fact, it can be as abusive as a beating, considering the long-term effects that the children face? So, we have two thorny legal questions, but we couldn't leave here without raising them, because they are ones that I know my colleagues will be interested in hearing your opinions on.

Dr. BESHAROV. I am a former New York City Family Court Prosector myself. Having had that experience, I would say that criminal prosecutions are almost always not advised. Most of these mothers are young, many are teenagers themselves as you have heard. Many come from the most disadvantaged circumstances themselves and to think of their drug addiction as some kind of free law act that justifies criminal prosecution, I think is to overstate the amount of freedom that they have to control what happens. Now, there are individual cases, but you sometimes have situations—for example, in fetal alcohol syndrome more so than in crack or cocaine, where a mother is giving birth to one, two or three children with a characteristic, signs of fetal alcohol syndrome, and the mother is told to stop using alcohol while pregnant and doesn't. Those cases start trying my patience but that is a very small, teensy, teensy fraction. For public policy, I think we should not think about criminal prosecution of these women.

You asked about termination and here I think you saw a demonstration of the problems and why I would encourage you to think about modifying the way Federal law is written. The Federal policy right now is for family preservation and people say, "Well, no, it is really about permanency planning and that there is just as much freedom to think about putting children in a permanent setting," but the fact of the matter is almost the entire amount of Federal funding is for family reunification, sending the children home. There has not been the kind of legal thinking, of programmatic thinking about one determining parental right. In the end, I think there is going to be a political compromise about that. I will suggest, and I think most people would agree at least I hope so, that is when there is a treatment program available, when the mother is offered participation in it, and she still refuses, and we do have cases like that, even today. There are some treatment slots in the City of New York. Parents are enrolled, some parents refuse, some parents have their children in care for years while they refuse one offer of treatment after another. At some point in those cases, and I think I would be on the shorter end of that than other people, I think we have to draw the line, and we say we have a treatment program for you, maybe it is not perfect, but it is there, you have not even tried, we owe it to the child to terminate parental rights. There aren't as I said tens of thousands of those cases, but there are many thousands in this country. Those children deserve a chance so I would start there in situations in which in a court of law you can prove there was an adequate treatment program and the mother refused it. Then I think you start—and lets assume that she has not been taking care of her child—I don't mean to make drug addiction, per se, a grounds for terminating parental rights, but if she can't care for her children and she refuses treatment, then I think there ought to be a broad consensus in favor of acting in favor of the children's interests.

Senator DODD. Judge.

Judge BARALL. We don't really disagree at all. First of all, let me give you the first issue first, the issue of criminal prosecution. It would be my opinion, rather ludicrous, to start criminal prosecution on a woman who is utilizing drugs when she is pregnant when we can't even deal with the drug dealer. In our State and again you make mention to Connecticut—we are talking about a drug dealer spending 10 percent of his time in jail. If I gave a drug dealer 3 years sitting in the adult court—by the way I am not sitting in the adult court. When I sat in adult court and gave the drug dealer 3 years, they would spend 2 years. Now what they are doing if you give the drug dealer 3 years, he will spend 3 months in jail, and I say he, it could be a she.

Senator **Dodd**. Let me be the devil's advocate for a minute. I appreciate the point about a woman who is addicted and so forth here. What about the woman who is addicted who sits there and beats her child that is born? You are not going to make the same exception in that case I would presume, would you, either of you?

Judge **Barall**. No.

Senator **Dodd**. Why would you make a distinction between that case and the case of someone sitting there with full knowledge, although granted it is an addiction? Doctors will tell you it is almost guaranteed you are going to pass on the addiction problem if——

Judge **Barall**. Well, I think it is really a social policy issue. At what point should the criminal process be born in to bear. If your brought the criminal process to everybody who violates the law, in circumstances, we might as well close up the courts and walk out because there wouldn't be enough police officers, there wouldn't be enough judges, there wouldn't be enough prosecutors, so you have to make reasonable distinctions as to what you are going to prosecute. So, at some point in time, the criminal process is not the answer to social problems. I think one of the issues that has to be addressed is how do you get people to accept—most people do not commit crime because there is a cop on the corner. Most people do not commit crime because it is not acceptable in their society to do it. If everybody decided to commit crimes, we are out of business as a country, so as I said, at some point, there has to be a social policy issue. I understand his concern, I am concerned about the same type of person where you might see the same person as a repeat, for example, a case that I was looking at that another judge decided. We had a woman of 25 where about 8 children have been removed—at 15, I mean that is staggering. Anyone would just want to pick that person up and just throw them somewhere. You can't help but get a vicious reaction to that type of behavior.

Senator **Dodd**. What about the second point?

Judge **Barall**. The second point was dealing with the——

Senator **Dodd**. Parental rights.

Judge **Barall**. I think there is always a tension between the, and the U.S. Supreme Court has held that there is some rights to a parent, i.e., you normally would have to remove only after clear of convincing evidence, rather than by preponderance of the evidence that are legalistic, so you do have to have a small substantial burden before you can remove. At the same time, there is a tension of the right of a child to be free from abuse and it seems to me that how I run my court, and one of the problems that you may have between States is—or even in the same jurisdiction, you may have different judges looking at it from a different perspective—I set expectations and I tell people that if these expectations are not followed, then I expect a petition for termination. If a whole panorama of things are set up in place and in fact there is a follow up and those things are in fact in place, not just illusions, and the person is not doing what they are supposed to do, than that child is entitled to have some permanency in their life and not have to wait 3 or 4 years for it. In my opinion, the process has to take place—one may be more than a year in most circumstances. And certainly if I asked a commitment, I would expect to see progress within the first 6 months. I am not saying the whole thing will be accomplished but if a person has a serious problem, you can always address that problem, but some steps have to be taken to address it so I think the issue is, yes, if you asked me how I would handle it, yes, I would terminate if the parent did not take appropriate steps. And, if it was not merely a State saying, "Yes, she didn't do it, but we didn't provide it," because we can have that too.

Dr. BESHAROV. I just want to add something here. There is an assumption in this discussion, I don't know how Dr. Finnegan would respond to this, but I think there is an assumption that every child who has been exposed to crack comes out defective. When, in fact, we are talking about just rare likelihood of some kind of birth defect and for that reason, it is more like the Uncle Harry syndrome. My Uncle Harry has smoked five packs of cigarettes a day for 50 years, he doesn't have cancer, therefore cigarettes don't cause cancer. Many of these young girls see other crack users giving birth to babies who don't look that different from other babies born to teen mothers. They might be underweight, they might be preemies, but very few come out with crack written across the forehead. We have not—there is not yet one Federal public announcement that says, "Don't use crack while you are pregnant," I believe that is the case. I don't think there are very many in the other States as well. Before we talk about prosecution, we ought to get that public education going.

Judge BARALL. And there is an additional component. I think your example of the additional component, i.e., the person who abuses the child, you know, we do have wealthy people who take drugs, who drink to excess, and because of their wealth, may have other methods to care for their children. Certainly we know in the past that people have sent their children to private schools and who are not capable of caring for their children, but nobody would remove them. What we are dealing with is a segment of society that is poor so that if the mother is incapable of caring and the grandmother can take care of it, I don't get too excited. As long as I have somebody in the household that is caring and responsible, so the second component of your question——

Senator DODD. Good point.

Judge BARALL [continuing.] Is the blood person that actually abuses.

Senator DODD. Let me ask you, Dr. Finnegan, and I want to ask you as well——

Dr. FINNEGAN. I know because I am getting all excited here. First of all, after what the Judge has said about how long people stay in jail after all of this prosecution takes place, I am envisioning it takes a long time, it takes a lot of money and all of those dollars are basically in my mind wasted because what they should be used for is to pay Elaine Fitzgerald, to pay other foster parents to pay for treatment, and if we looked at this the way we should which is as a diseased entity, we certainly would not think of putting a diabetic woman who by the way, if she does not take her insulin, and if she does not keep her diet, will have a defective baby. But, we don't put her in jail if she doesn't follow our orders. Well, what about all those mothers who smoke nicotine? Thirty percent of mothers come into prenatal clinics with a cigarette. This drug can cause many, many problems. Are we going to put all of them in jail? I mean, it is really an inappropriate way to look at a major health problem and I think that as I said before, we have got all of this information out there, we need to do a little bit more. The Mayor mentioned acupuncture. There is, by the way, the clinic that he mentioned here at Lincoln Hospital, it is being evaluated by Dr. Doug Lipton and I think that is another potential on the horizon but the fact is that we have a lot of information. Let's try to get those moneys. Instead of the hysteria of going though putting the mothers in jail, lets use those moneys where we need them right now which is, as I said, in foster care, in treatment and in trying to deal with it as it is in this point in time.

Senator DODD. Thank you. Mr. Marion.

Mr. MARION. Well, I just wanted to add that——

Senator DODD. Why don't you address the parental termination issue too, keeping your focus of attention on preservation.

Mr. MARION. Well, my answer is obviously at some point, you have to take a kid out of the home, there is no question about that. There is a point where child abuse, where active substance abuse, where—I mean, we have seen cases, to be very graphic, where AIDS infected hypodermic needles are left in a living room and kids are playing in that room and can easily stick themselves and hurt themselves. That is a horrible situation. But I think it is important that we not have the idea that we have done something, because we call it Child Protective Services. With all reference to the City and the Mayor, this is not an agency that is able to come in and solve everything because we have made a telephone call and said I am reporting this, I am taking action, they are going to snatch these kids. Often times that doesn't happen. Often times they walk in and say there is a bed and a refrigerator, I don't know what you are all hopped up about that this kid is in danger.

To the extent that families can be kept together, they should be kept together. Not at the point where the child's welfare is at stake and it is a very hard call when that is. It is not something that is simple.

Senator DODD. I didn't mean to suggest that it was by the way. I can see amendments being offered and on the floor of the Senate this year, when some of these issues come up. I don't think I have thought it through as carefully as obviously any of you have here, but I can see the temptation, given the frustration. There is one upmanship on this "War on Drugs," who can get tougher. You can see the condition that it wouldn't take a terribly creative legislator to try and craft amendments in such a way so it actually encouraged our judicial systems or required our judicial systems to prosecute people where children are born with cocaine addictions as a result of parental substance abuse. So, I can see the issue coming. Your comments, all of you here today, will be very helpful I think in that debate, because it is a debate that will come.

Mr. MARION. I just want to add that I think that makes news too. You can go in and expose these——

Senator DODD. Oh, sure.

Mr. MARION. There is nothing sexy though about giving the kid the vaccinations that he is supposed to get or she is supposed to get from birth, there is nothing sexy about doing well in school and passing your subjects, and those are the things we are talking about. Delivering the services so those things can happen and they don't get votes and they don't keep people.

Dr. **Besharov.** As you probably know, there is going to be a Ways and Means bill on this subject and I hope there will be a Labor and Human Resources bills.

Senator **Dodd.** Their will be a Labor and Human Resources bill.

Dr. **Finnegan.** The other thing that the Senate should think about is that if we start using your intoxicologies, we are going to uncover some of those people that we mentioned today that are not from below socioeconomic class, they are not from ethnic minorities but in fact are individuals who are in the private services. At Jefferson just this summer, we looked at 852 urine toxicologies as an anonymous study and found that 14.5 percent of those mothers who came into the delivery unit had cocaine alone or cocaine with marijuana or cocaine with opiates in their urines. I might add that the hospital is a hospital that serves 50 percent of the women who deliver there are private patients, and 50 percent are on medical assistance, and therefore when looking at that 14.5 percent, it was equally distributed between the private patients and the indigent patients, so that I think we are talking about surfacing a much larger problem then we are really aware of.

Senator **Dodd.** I regret we are running out of time. I can literally spend the next day or so with all four of you. Your testimony has been tremendous and most helpful to me. I must tell you, I would like to stay in touch. I may have some more questions that I would submit to you in writing as well, rather than take your time today. It is extremely helpful, the things that you have said here. I will pass them along to my colleagues on the subcommittee as well as the full committee as we move forward with the legislation that we are looking at here as well. It is just a very worthwhile subjectyou have busy schedules all of you, and I am very, very grateful you have come, in the case of you, Judge, and you, Dr. Finnegan, coming from out of State to be here. We are honored to have the Mayor here as well to talk about the importance of the issue and as he pointed out, New York is sort of a laboratory for an awful lot of these things that go on. So, I am grateful again to all four of you and our earlier witnesses as well for taking the time to be with us today. And I tell them as well we may have some additional questions for them, which we would submit in writing, and ask you to respond as quickly as possible.

[Additional statements and material submitted for the record follow:]

Prepared Statement of Kary L. Moss on behalf of the American Civil Liberties Union

Mr Chairman, members of the Subcommittee, we appreciate the opportunity to present the views of the American Civil Liberties Union on the question of substance abuse and its effects on children and their parents. The American Civil Liberties Union is a non-partisan organization of more than 275,000 members devoted to protecting the Bill of Rights and to the equal protection of our nation's laws.

Much recent attention has been focussed on the often tragic effects of substance abuse on infants and young children, the response of some in the law enforcement community has been to penalize women for behavior during pregnancy and to call for mandatory drug screening of newborn children and mandatory removal of parental rights if a positive test is obtained. Our testimony will focus on the legal and public health effects of such policies.

In 1987 Theresa L.[1] found out she was pregnant. Although the father did not want the child, she decided to go ahead with the pregnancy, even if it meant losing her boyfriend. She immediately set up a prenatal care appointment at South Nassau Communities Hospital. At her first visit she gave her doctor her entire medical history, including her experience smoking marijuana and snorting cocaine at several parties a few years earlier. She quit her job as a bartender, to avoid secondhand exposure to cigarettes, and eliminated all caffeine from her diet. She joined a Lamaze class and never missed a prenatal appointment. She refused to take any medication, including Tylenol or Maalox, and she prepared the baby's room.

She went into labor near her due date. As friends and family gathered around her, a friend, who also was a nurse, advised her to smoke a joint of marijuana to relieve the stress and pain. Late that night she went to the hospital and gave birth to a healthy baby boy. The hospital refused to release her son, however, because of a positive test for THC, the chemical found in marijuana. Immediately after, Child Protective Services (CPS) notified Theresa that she had lost temporary custody of her son following the family court's approval of an emergency removal petition filed by CPS. At the hearing CPS did not put any witnesses on the stand. The drug test alone stood as evidence of her parental unfitness. On Theresa's behalf, her mother, doctor and social worker all testified about her concern for her baby's well-being, as evidence of parental fitness. In particular, her doctor testified that the fetus had not been at any risk due to the positive toxicology and declared "the infant is perfect." The social worker, who had never before testified for a mother, stated she did not believe the baby was at any risk.

Nevertheless, the judge hearing the case indicated concern with Theresa's "bad judgment" and decided that the Child Protective Services would continue temporary custody while Theresa's mother would be given physical custody. The judge ordered that Theresa not be left alone with her child. Theresa's mother had to quit her job to supervise her grandchild and had to borrow money to meet expenses. After urging by a Child Welfare representative, Theresa went to a drug-treatment program but after one visit the treatment social worker wrote Theresa a letter stating she did not appear to have a drug problem and should not be mandated to treatment. Several months after the initial hearing, another hearing was convened. The judge gave child welfare officials several more months to come up with evidence that Theresa was neglectful. When they could not, nine months after the birth, the court dismissed the case.

Theresa L. is not alone. In many jurisdictions, hospitals seek to remove every baby born with a positive toxicology from its mother. CPS then goes into Family Court to obtain approval for an emergency removal which is rarely, if ever, turned down. CPS typically then files a neglect petition against the mother and the mother tries to have the child returned. While the legal petitions are pending, the child is placed in foster care, or perhaps with other family members.

Counties with such removal policies do not discriminate between the occasional user and the habitual drug user. They place no emphasis on legal drugs, such as alcohol or tobacco, both of which may be harmful if taken in excess. The "better safe than sorry" approach does not necessarily benefit the newborn if removal means even temporary loss of a fit parent.

Presuming parental unfitness from a positive toxicology is woefully inadequate: A drug test says only that a drug was ingested in the last 24-72 hours. It does not distinguish between the one-time user and an addict. Women who are not addicts are therefore lumped together without distinction with those who are. One can only speculate as to how many good parents had occasionally used marijuana, for example, prior to the birth of their children. It would be over-reaching to infer that each of them is a neglectful parent. It is not difficult to go to a house and assess if it is physically equipped for an infant and if that infant is well cared for. But when a positive toxicology alone triggers removal, child welfare officials often do not even do that. Moreover, false positives are a quite common occurrence, magnified by human error. Children may consequently be removed from homes that are far better than any foster care home, given the overburdened state of foster care today in most states. *See* Armstrong, L., *Solomon Says: A Seakout on Foster Care* (Pocket Books 1989).

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[1] Facts from *In the Matter of Ryan*, New York Supreme Court Appellate Division, 2nd Department (Mo. No. 889)

Given the inability of positive drugs tests to predict future harm, use of a positive toxicology alone as evidence of neglect makes little sense given the focus of most state child neglect laws that require that the child be in "imminent danger." *E.q.*, F.C.A. Sec. 1012 *et seq.* (New York). This standard evolved in the early 1970's as a response to imprecise, broad language that focussed primarily on parental conduct rather than harm to the child. This led to a highly arbitrary system where intervention was based on community values without considering the harm which could result. As a result, children were often taken away from adequate homes because their families engaged in parenting in ways that conflicted with majoritarian notions of child-rearing. Now most states look to whether the child is at risk of future harm. A positive toxicology alone cannot give that information.

Moreover, use of a positive toxicology to trigger removal runs counter to laws that mandate the provision of preventive services prior to removal in order to keep the family together whenever possible. It is irresponsible to not offer a family help before breaking it up.

Dr. Sidney H. Schnoll and Dr. Lori Karan, of the Medical College of Virginia Hospitals recently noted in a letter to the *Journal of the American Medical Association* that use of tests without proper caution will drive women away from health care:

> The issue of collecting urine toxicology test results on all pregnant women must be looked at in the context in which the test is performed. We agree that mandatory drug testing of all pregnant women to punish those with positive urine drug tests and separate them from their children may have deleterious effects for mother, child, and society alike. The most deleterious effect would be to discourage pregnant addicted women from seeking treatment. . . .
>
> At present, it is extremely difficult to get pregnant addicts into the few programs that are designed to provide both obstetric care for high-risk patients and treatment for addiction. Using medical information such as a urine toxicology test result as the sole criterion to determine the suitability of the woman as a mother or to bring criminal charges only compounds the serious problems they already face and discourages them from seeking prenatal care and addiction treatment. . . .
>
> As physicians, we must decide whether medical tests like urine toxicology screens should be used for political purposes or remain part of a comprehensive health care delivery system. We feel strongly that the subversion of medical tests for other than medical purposes directly related to the clinical care of the patient destroys the value of the test and compromises the role of the physician.

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They continue that tests may be used for treatment purpose:

> However, using screening questionnaires and urine tests to identify mothers at risk for chemical dependency and refer them for obstetric monitoring and chemical dependency treatment is an appropriate use of urine toxicology data.

Id.

There are thus compelling reasons to use these tests use carefully. Another problem is presented by the reporting of t mor results to child welfare authorities, a practice which often who penalizes poor women and women of color more than any other group. In a number of jurisdictions, women in government-subsidized facilities are routinely tested for drug use when women who can afford private health care are not tested or reported. One recent study of Pinnellas County, Florida, conducted by the National Association of Perinatal Addiction Research and Education, found that African-American women were ten times more likely to be reported to child abuse authorities than were white women.[2]

After reviewing records from the health department during the same period, the zip codes, race, and drug use patterns of pregnant women were compared with the two groups of public and private patients. The researchers found that 14.8 percent of all the women tested positive for alcohol, marijuana, cocaine, and/or opiates, with white women 1.09 times more likely to have used alcohol or drugs prior to their first visit to the doctor. Yet, of the 133 pregnant women reported to county health authorities, 85 were African-American and 45 were white. The study conclucded that African-American women were 9.58 times as likely to be reported for substance dependency in pregnancy as compared to white women, even though white women were more likely to have used drugs prior to their first visit to the doctor. thus, if more poor, women of color are reported, it will be these women who lose their children.

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[2] National Association for Perinatal Addiction and Education, press release, September 18, 1989.

Use of positive toxicologies also ignores the effects of drugs on the male reproductive function, including possible effects on the course of pregnancy and the well-being of a future child. It also ignores the effects of drug use on the existing affected population and leaves fathers who may engage in drug use completely out of the picture. It therefore singles out for state scrutiny mothers, solely because of their prenatal behavior. This practice violate well-established constitutional principles of law.

As Judge Gallet stated in *In re Fletcher*, Docket No. N-3968,88 (Bronx Family Court 1988), a New York case in which the court rejected the use of positive toxicologies as evidence of neglect:

> I see no authority for the State to regulate women's bodies merely because they are pregnant. By becoming pregnant, women do not waive the constitutional protections afforded to other citizens. To carry [the Law Guardian's argument] to its logical extension, the State would be able to supersede a mother's custody right to her child if she smoked cigarettes during her pregnancy, or ate junk food, or did too much physical labor or did not exercise enough. The list of potential intrusions is long and constitute entirely unacceptable violations of the bodily integrity of women.

It should not have taken Theresa L. nine months to get her baby back. No parent or child should have to go through that trauma. There is no reason to cut corners when child welfare authorities can undertake a more careful review of the parenting abilities of both parents. We should demand no less.

Senator DODD. I want to thank Patty Cole of the subcommittee staff who is sitting behind me, who has done a very, very good job in organizing this hearing; Rich Tarplin, who is the staff director for this subcommittee, as well as Jackie Ruff and Molly Guth of the subcommittee staff, for doing excellent work as well; and Jason Isaacson of my office, Stanley Israelite from my Connecticut office, who is here as well, and Chuck Bunnell is here as well from my staff, so we thank all of them for their fine work. This subcommittee will stand adjourned until further call of the chair.

(Whereupon the hearing was adjourned subject to the call of the Chair.)

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